
State: District of Columbia **Filing Company:** Companion Life Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: Group Dental/CL-DEN-1000-P-DC FORM

Filing at a Glance

Company: Companion Life Insurance Company
Product Name: Group Dental
State: District of Columbia
TOI: H10G Group Health - Dental
Sub-TOI: H10G.000 Health - Dental
Filing Type: Form
Date Submitted: 11/14/2019
SERFF Tr Num: EWLE-132133192
SERFF Status: Submitted to State
State Tr Num:
State Status:
Co Tr Num: CL-DEN-1000-P-DC FORM

Implementation: On Approval
Date Requested:
Author(s): Suzanne Heasley, Muhammed Gulen, Angie Damiani
Reviewer(s):
Disposition Date:
Disposition Status:
Implementation Date:

State: District of Columbia **Filing Company:** Companion Life Insurance Company
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General Information

Project Name: Group Dental
Project Number: CL-DEN-1000-P-DC FORM
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 11/14/2019
State Status Changed:
Created By: Angie Damiani
Corresponding Filing Tracking Number: EWLE-132133191

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: Angie Damiani

Filing Description:

RE: Companion Life Insurance Company NAIC # 77828

CL-DEN-1000-P-DC Group Dental Policy
CL-DEN-1000-C-DC Group Dental Certificate
CL-DEN-1000-APP Group Dental Application
CL-DEN-1000-ENR Group Dental Enrollment Form

Dear Sir or Madam:

This submission is being made on behalf of Companion Life Insurance Company. These forms are submitted for review and approval. These forms are new and not intended to replace any previously approved forms.

The corresponding rate filing has been made under SERFF Tracking # EWLE-132133191

These forms are designed to provide group dental coverage.

A variability statement and readability certification have been attached to this submission. All bracketed numbers are variable to the extent allowable by your state's law.

The forms are in final print, subject to minor variations in formatting, duplicating, shading and fonts. In addition, the Application may be reproduced electronically which could result in format changes. While every effort is made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

Should you have any questions or need any additional information, please do not hesitate to call me at 972-850-0850.

Sincerely,

Melanie King
Compliance Consultant
Lewis & Ellis, Inc.
mking@lewisellis.com

State: District of Columbia **Filing Company:** Companion Life Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
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Company and Contact

Filing Contact Information

Muhammed Gulen, Compliance Consultant mgulen@lewisellis.com
700 Central Expressway South 972-850-0853 [Phone]
Suite 550
Allen, TX 75013

Filing Company Information

(This filing was made by a third party - lewisandellisincorporated3)

Companion Life Insurance Company	CoCode: 77828	State of Domicile: South Carolina
7909 Parklane Road, Ste 200	Group Code: 661	Company Type:
Columbia, SC 29223-5666	Group Name: Companion Life Ins Co	State ID Number:
(803) 735-1251 ext. [Phone]	FEIN Number: 57-0523959	

Filing Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

State:	District of Columbia	Filing Company:	Companion Life Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Dental		
Project Name/Number:	Group Dental/CL-DEN-1000-P-DC FORM		

Form Schedule

Lead Form Number: CL-DEN-1000-P-DC								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Policy	CL-DEN-1000-P-DC	POL	Initial		56.900	CL-DEN-1000-P-DC.pdf
2		Certificate	CL-DEN-1000-C-DC	CER	Initial		51.200	CL-DEN-1000-C-DC.pdf
3		Application	CL-DEN-1000-APP	AEF	Initial		50.400	CL-DEN-1000-APP.pdf
4		Enrollment Form	CL-DEN-1000-ENR	AEF	Initial		51.100	CL-DEN-1000-ENR.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NAP	Network Access Plan
NOC	Notice of Coverage	OTH	Other
OUT	Outline of Coverage	PJK	Policy Jacket
POL	Policy/Contract/Fraternal Certificate	POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider
PRC	Provider Contract/Provider Addendum/Provider Leading Agreement	PRD	Provider Directory



COMPANION LIFE INSURANCE COMPANY
[7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
P.O. Box 100102, Columbia, South Carolina 29202-3102]¹
[(803) 735-1251]²

(A stock insurance company, herein called the “Company”)
will pay benefits according to the terms and conditions of this Policy.

Name of Policyholder: [ABC Corporation]³

Policy Number:
[123-45-67890]⁴

Effective Date:
[January 1, XXXX]⁵

Policy Anniversary Dates:
[January 1st]⁶

Place of Delivery:
District of Columbia

In consideration of the application made by the Policyholder, and receipt of any and all premiums when due, Companion Life Insurance Company agrees to provide the coverage described herein subject to all provisions of this Policy and any amendments added to this Policy.

This Policy shall renew each Policy Anniversary Date unless terminated in accordance with the Termination of Policy provision. The Entire Contract provision of this Policy determines all rights and benefits of persons who are insured hereunder.

The Company urges the Policyholder to examine this Policy closely. If the Policyholder is not satisfied with it, the Policyholder may send it back to the Company or its Administrator for any reason within 10 days after the date the Policyholder receives it. If returned, the Policyholder’s insurance will be canceled, and any premium paid will be refunded in full.

In witness whereunto, Companion Life Insurance Company has caused this Policy to be signed and shall take effect on the Effective Date specified above.

Signed for by the Company

[A handwritten signature in black ink, appearing to read 'John Wilbur', enclosed within a large square bracket.

John Wilbur
President]⁷

GROUP DENTAL INSURANCE POLICY
OPTIONALLY RENEWABLE AS
DESCRIBED WITHIN

For service or questions about this Policy, please address any inquiries to [ABC Administrator, 123 Any Street, Any City, Any State 00000]⁸, call [1-800-736-7872]⁹ or via website [www.companionlife.com]¹⁰.

SECTION 1 - TABLE OF CONTENTS

	<u>SECTION</u>
Table of Contents	1
Schedule of Benefits	2
Premiums.....	3
General Provisions	4

SECTION 2 - SCHEDULE OF BENEFITS

The Schedule of Benefits for this Policy benefits listed below are shown in the Certificate, as incorporated into this Policy.

Class I	Preventive Services
Class II	Basic Services
Class III	Major Services
Class IV	Orthodontic Services ¹¹

The Schedule of Benefits will control the:

- 1) benefit amounts and maximum limits;
- 2) eligibility and Effective Date requirements; and
- 3) other schedule amounts and limits.

SECTION 3 - PREMIUMS

Initial Monthly Premium Rates

The first premium is due and payable on the Effective Date of this Policy. Subject to this Policy's Grace Period provision, all premiums after the first must be paid when or before they are due.

Grace Period

After the first premium is paid, the Company will allow the Policyholder no less than a 31-day grace period for the payment of all premiums. During this grace period, this Policy will stay in force. If the premium due is not paid by the end of the grace period, this Policy will terminate after the last day of the grace period. If the Policyholder gives the Company written advance notice of an earlier cancellation date, this Policy will terminate on the earlier date. Premium is due for each day this Policy is in force. The Policyholder is liable for the premium due for coverage through the grace period.

Reinstatement

If any renewal premium is not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by the Company or by any agent duly authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. If the Company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Policyholder in writing of its disapproval of such application.

Premium Payments

Premium payments are due and payable in full to a place designated by the Company or, with respect to the initial premium payment, premium payments may be made to an authorized agent of the Company.

If any insurance is added, increased, or becomes effective after this Policy is in force, the premium charges will begin on:

- 1) the day the coverage is effective if it is also the first day of a policy month; or
- 2) the first day of the next policy month.

For insurance which is terminated, premium charges will stop as of the first day of the next policy month.

Premiums may be calculated by any other method which both the Company and the Policyholder agree to in writing.

Premium Changes

We have the right to change the premium We charge. If We plan to make a change, We will send a notice to the Policyholder's last address on record at least 31 days before the date of change.

SECTION 4 - GENERAL PROVISIONS

Entire Contract

The contract between the parties consists of:

- 1) this Policy;
- 2) the application of the Policyholder, which is made a part of this Policy when issued;
- 3) the Certificate;
- 4) any endorsements, amendments, or riders; and
- 5) the enrollment forms, if any, of each Insured.

All statements made by the Policyholder and Insured shall be deemed representations and not warranties, and no statement made by an Insured shall void the insurance or be used in defense to a claim hereunder unless a copy of the instrument containing such statement is or has been furnished to such Insured.

Change in This Policy

The Company reserves the right to make changes in this Policy. The Company will give the Policyholder 31 days' advance written notice of any change. No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing on company letterhead and/or email, approved by one of Our officers: (1) the President; (2) a Vice President; or (3) the Secretary. The approval must be endorsed on or attached to this Policy.

Clerical Error

Clerical errors or delays in keeping records for this Policy:

- 1) will not deny insurance which would otherwise have been granted;
- 2) will not continue insurance which otherwise would have ceased; and
- 3) may call for an adjustment of premium or benefits to correct the error.

Certificates

The Company will supply individual Certificates for each Insured. The Certificate will describe:

- 1) the insurance benefits;
- 2) to whom benefits will be paid;
- 3) any limitations of this Policy; and
- 4) all other essential features of this Policy.

If more than one Certificate is issued under this Policy to an Insured, only the last one issued will be in effect.

If requested, the Certificates will be provided electronically at no additional cost.

Misstatement of Age

If the date of birth or age of any Individual Insured has been misstated, an adjustment of premium will be of an amount that the premium paid would have purchased at the correct date of birth or age.

Legal Action

No legal action can be brought against Us until at least 60 days after the Insured sends Us the required proof of loss. No such action may be brought against Us after three years after proof of loss is required.

Conformity with State Laws

If any provision of this Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law. If any change to state or federal law affects the Company's liability under this Policy, the Company may change this Policy, the premiums or both.

Such change:

- 1) will be effective as of the date of change to the state or federal law; and
- 2) will not be made until the Company gives the Policyholder 31 days' notice.

Incontestability

The validity of this Policy cannot be contested after three years from its date of issue, except for nonpayment of premiums. After coverage for an Insured Individual has been in force for three years, the Company cannot: (a) void the coverage; or (b)

deny a claim for loss that starts after the two-year period, because of statements in the application unless they were fraudulent misstatements.

Nothing herein should be construed to prevent the Company from denying any claim on the basis that an individual was not eligible for coverage.

Not in Lieu of Workers' Compensation

This Policy is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Physical Examination

We, at Our own expense, may have the Insured Individual examined when and as often as it may reasonably require during the pendency of a claim hereunder where it is not prohibited by law.

Coordination of Benefits

This coordination of benefits (COB) provision applies when an Insured Individual has dental care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary Plan. The primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary Plan is the secondary Plan. The secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

The following definitions apply only to this provision of this Policy,

A. A "**Plan**" is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); dental care components of long-term care contracts; dental benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-dental components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. "**This Plan**" means, in a COB provision, the part of the contract providing the dental care benefits to which the COB provision applies, and which may be reduced because of the benefits of other Plans. Any other part of the contract providing dental care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as orthodontic benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determines whether This Plan is a "primary Plan" or "secondary Plan" when compared to another Plan covering the Insured Individual.

When This Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When This Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the primary Plan's benefits, so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. **“Allowable Expense”** is a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Insured Individual. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Insured Individual is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Individual is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

- (1) If an Insured Individual is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- (2) If an Insured Individual is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- (3) If an Insured Individual is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan’s payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable Expense used by the secondary Plan to determine its benefits.
- (4) The amount of any benefit reduction by the primary Plan because a person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second opinions and preferred provider arrangements.
- (5) If the primary Plan is a Closed Panel Plan with no out-of-network benefits and the secondary plan is not a Closed Panel Plan, the secondary Plan shall pay or provide benefits as if it were primary when no benefits are available from the primary Plan because the Insured Individual uses a non-panel provider, except for emergency services that are paid or provided by the primary.

E. **“Claim Determination Period”** is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person is covered by a Plan during a portion of a Claim Determination Period if that person’s coverage starts or ends during the Claim Determination Period. However, it does not include any part of a year during which a person has no coverage under This Plan, or before the date this COB provision or a similar provision takes effect.

F. **“Closed Panel Plan”** is a Plan that provides health benefits to Insured Individual primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

G. **“Custodial Parent”** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order-Of-Benefit Determination Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- A. The primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. (1) Except as provided in paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the plan provided by the contract holder. An example of this type of situation is insurance type coverage that is written in connection with a Closed Panel Plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

(1) **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

(2) **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial Parent;
- The Plan covering the spouse of the Custodial Parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary Plan. The Plan covering that same person as a retired or laid-off employee is the secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary Plan and the COBRA or state or other federal continuation coverage is the secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) **Longer or Shorter Length of Coverage.** The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary Plan and the Plan that covered the person the shorter period of time is the secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the primary Plan.

Effect on The Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary Plan will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the primary Plan. The secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

B. If an Insured Individual is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

C. If an Insured Individual is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the Insured Individual. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Termination of Policy

The Company may terminate this Policy for the following reasons by giving the Policyholder 31 days written notice:

- 1) the Policyholder fails to furnish any information which the Company may reasonably require;
- 2) the Policyholder fails to perform any of his other obligations pertaining to this Policy; or
- 3) less than 100% of the persons eligible for non-contributory coverage are insured.

This Policy will terminate, subject to the grace period, if any premium is not paid when due.

Termination of this Policy under any conditions will not prejudice any payable claim which occurs while this Policy is in force.

The Policyholder or the Company may terminate this Policy by giving the other party at least 31 days prior written notice.

Terminations may take effect on an earlier date when both the Policyholder and the Company agree.

Data to Be Furnished

The Policyholder, or any other person designated by the Policyholder, will give the Company all information the Company needs regarding matters pertaining to the insurance. At any reasonable time while this Policy is in force and for 12 months after that, the Company may inspect any of the Policyholder's documents, books, or records which may affect the insurance or premiums of this Policy.

The Policyholder will, upon Our request, give Us:

- 1) the names of all persons initially eligible for coverage;
- 2) the names of all additional persons who become eligible for coverage;
- 3) the names of all persons whose insurance is to be changed;
- 4) the names of all persons whose eligibility or insurance is terminated; and
- 5) any data necessary to administer the insurance provided by this Policy.

If the Policyholder gives the Company any incorrect information, the relevant facts will be determined to establish if insurance is in effect.

No person will be deprived of insurance to which he is otherwise entitled or have insurance to which he is not entitled because of any misstatement of fact by the Policyholder. Any required adjustment may be made in premiums or benefits.

Right to Audit

The Company reserves the right to audit the Policyholder's billing records and premium accounting practices. If the Company discovers:

- 1) an underpayment of premium by the Policyholder, the Policyholder will be obligated to remit the underpayment amount in a timely manner; or
- 2) an overpayment of premium, the Company will return any overpayment amount in a timely manner for the previous two-year period.

Time Period

All periods begin and end at 12:01 A.M., standard time, at the Policyholder's address.

¹ The Company's current address and mailing address are bracketed in the event that this information is changed in the future.

² The Company's current phone number is bracketed in the event that this information is changed in the future.

³ The variable area [ABC Corporation] will reflect the name of the Policyholder.

⁴ The variable area will reflect the Policy Number.

⁵ The variable area will reflect the Policy Effective Date.

⁶ The variable area will reflect the Policy Anniversary Date.

⁷ The variable area will always be included; they are bracketed in the event the officer and title change.

⁸ This information will be revised for personalization of the Policy as issued.

⁹ The phone number is bracketed in the event that this information is changed in the future.

¹⁰ The website is bracketed in the event that this information is changed in the future.

¹¹ This variable may be excluded in its entirety if the group does not select orthodontic benefits.



COMPANION LIFE INSURANCE COMPANY
[7909 PARKLANE ROAD, SUITE 200, COLUMBIA SC 29223-5666
P.O. Box 100102, Columbia, South Carolina 29202-3102]¹
[(803) 735-1251]²

Policy Number [123-45-67890]³ **Certificate Effective Date:** [January 1, XXXX]⁴
[Certificateholder: [John Doe]⁵ **Policyholder:** [ABC Corporation]⁷
Policy Anniversary Date: [January 1, XXXX]⁸

This Certificate is issued to the Certificateholder and subject to the laws of the jurisdiction within which the Policy has been issued.

In consideration of the application made by the Policyholder, the applications of the Certificateholders and receipt of any and all premiums when due, the Company agrees to provide the coverage described herein subject to all provisions of the Policy and any amendments added to the Policy.

The Policy may be amended or cancelled without the consent of the Insured.

This Certificate replaces all certificates previously issued to the Insured under the Policy.

The Policy shall renew on each Policy Anniversary Date unless terminated in accordance with the Termination of Insurance provision. The Entire Contract provision of the Policy determines all rights and benefits of persons who are insured hereunder.

ANY DENTAL CARE INSURANCE BENEFITS PAYABLE UNDER THE POLICY DESCRIBED HEREIN MAY BE COMBINED WITH THE BENEFITS PAYABLE UNDER OTHER PLANS OR PROGRAMS SO THAT THE TOTAL REIMBURSEMENT FOR ALLOWABLE EXPENSES DOES NOT EXCEED THE ACTUAL EXPENSES INCURRED. SEE THE COORDINATION OF BENEFITS PROVISION FOR DETAILED INFORMATION.

In witness whereunto, Companion Life Insurance Company has caused this Certificate to be signed and shall take effect on the Certificate Effective Date specified above.

Signed for by the Company

A handwritten signature in black ink, appearing to read 'John Wilbur', written over a horizontal line.

[

John Wilbur
President]⁹

**GROUP DENTAL INSURANCE CERTIFICATE
OPTIONALLY RENEWABLE AS
DESCRIBED WITHIN**

For service or questions about the Policy, please address any inquiries to [ABC Administrator, 123 Any Street, Any City, Any State 00000]¹⁰, call [1-800-736-7872]¹¹ or via website [www.companionlife.com]¹².

SECTION 1 - TABLE OF CONTENTS

	<u>SECTION</u>
Table of Contents	1
Schedule of Benefits	2
Definitions.....	3
Eligibility and Enrollment.....	4
Termination/Nonrenewal/Continuation.....	5
Benefits/Coverage	6
Limitations and Exclusions	7
General Provisions.....	8
Claims Procedures	9

SECTION 2 - SCHEDULE OF BENEFITS

Classes Eligible for Insurance	[All Active [Employees][,][Retirees]][, and] [Non-Permanent Employees] ¹³	
Persons Covered	Eligible [Employees][and][Retirees] [Non-Permanent Employees][and Dependents] ¹⁴	
[Employees][,][Retirees][, and][Non-Permanent Employees] ¹⁵ Contributions	[Contributory] [Voluntary] ¹⁶	[Non-contributory]
Eligibility Waiting Period	[0-365 days] ¹⁷	
Prior Insurance Credit	[Yes][No] ¹⁸	
Recommended Predetermination of Benefits Amount Applicable to All Classes of Service	[\$300-500] ¹⁹	
	<u>PPO</u>	<u>Non-PPO</u>
[Initial] ²⁰ Maximum [Contract][Calendar] ²¹ Year Benefit Applicable to Each Insured Individual for Covered Services [Other Than Orthodontia] ²² [Preventive Services does not count toward Maximum Year Benefit] ²⁵	[\$500–99,999] ²³	[\$500–99,999] ²⁴
[Lifetime][Annual Contract Year][Annual Calendar Year] ²⁶ Deductible Amount Applicable to Each Insured Individual for Covered Services [Other Than Orthodontia] ²⁷	[\$0-1,000] ²⁸	[\$0-1,000] ²⁹
Family Deductible – Number of Insured Individuals	[0–4] ³⁰	[0–4] ³¹ ³²
Deductible Waived for Class I Services	[Yes][No] ³³	[Yes][No] ³⁴
Benefit Waiting Period for Class II Services Months] ³⁶	[None-24 Months] ³⁵	[None-24
Benefit Waiting Period for Class III Services Months] ³⁸	[None- Months] ³⁷	[None-24
Benefit Waiting Period for Class II Services for Late Entrants months] ⁴⁰	[None-24 months] ³⁹	[None-24 ⁴¹
Benefit Waiting Period for Class III Services for Late Entrants months] ⁴³	[None-24 months] ⁴²	[None-24 ⁴⁴
<u>Orthodontic Services</u>	[Yes][No] ⁴⁵	
Lifetime Deductible Amount Applicable to Each [Insured][and] [Dependent/Dependent Child] ⁴⁶ for Orthodontic Services \$1,000] ⁴⁸	[N/A][None-\$1,000] ⁴⁷	[N/A][None-
Lifetime Maximum Applicable to Each [Insured][and] [Dependent/Dependent Child] ⁴⁹ for Orthodontic Services \$99,999] ⁵¹	[N/A][None-\$99,999] ⁵⁰	[N/A][None-
Benefit Waiting Period for Orthodontic Services Months] ⁵³	[N/A][None-24 Months] ⁵²	[N/A][None-24
Takeover Credit for Orthodontic Services	[N/A][Yes][No] ⁵⁴	⁵⁵

Percentage of Covered Dental Expenses Payable:

Covered Expenses in excess of the Deductible will be paid by Companion Life up to the Maximum [Contract][Calendar]⁵⁶ Year Benefit [or Orthodontic Lifetime Maximum, as applicable,]⁵⁷ at the benefit rates shown below:

		[1 st Year] ⁵⁸		[2 nd Year] ⁵⁹		[3 rd Year+] ⁶⁰	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
		[50-100%] ⁶¹	[50-100%] ⁶²	[50-100%] ⁶³	[50-100%] ⁶⁴	[50-100%] ⁶⁵	[50-100%] ⁶⁶
Class I	Preventive Services						
Class II	Basic Services	[0-100%] ⁶⁷	[0-100%] ⁶⁸	[0-100%] ⁶⁹	[0-100%] ⁷⁰	[0-100%] ⁷¹	[0-100%] ⁷²
Class III	Major Services	[0-100%] ⁷³	[0-100%] ⁷⁴	[0-100%] ⁷⁵	[0-100%] ⁷⁶	[0-100%] ⁷⁷	[0-100%] ⁷⁸
Class IV	Orthodontic Services	[0-100%] ⁷⁹	[0-100%] ⁸⁰	[0-100%] ⁸¹	[0-100%] ⁸²	[0-100%] ⁸³	[0-100%] ^{84 85}

Takeover Provisions

86

Standard Takeover – The Benefit Waiting Period will be reduced by the amount of time the [Employees][and][Retirees]⁸⁷ were insured under the Policyholder's prior plan for similar benefits. The current dental plan must have been in force continuously for at least 12 months prior to the Effective Date of the Policy and the [Employees][and][Retirees]⁸⁸ must have been insured by the prior plan on its date of termination.⁸⁹

Preferred Takeover – The Benefit Waiting Period will be waived under the Policy if the [Employees][and][Retirees]⁹⁰ were covered under the Policyholder's prior plan for similar benefits. Benefit Waiting Periods are waived for all current [Employees][and][Retirees]⁹¹. All Benefit Waiting Periods will continue to apply to future [Employees][and][Retirees]⁹². The current dental plan must have been in effect continuously for at least 12 months prior to the Effective Date of the Policy and the [Employees][and][Retirees]⁹³ must have been insured by the Policyholder's prior plan on its date of termination. Takeover applies to Class III (Major) [and Class IV (Orthodontics)]⁹⁴ procedures.⁹⁵

Enhanced Takeover – Waiting periods are waived for existing [Employees][and][Retirees]⁹⁶ [and for all future Employees]⁹⁷[and] [Retirees]⁹⁸.

99

Incentive Plan Takeover – If the group dental plan replaced a prior group incentive dental insurance plan, and takeover benefits have been approved by Companion Life, all [Employees][and][Retirees]¹⁰⁰ insured under the prior plan are eligible for appropriate credit for time served under the prior dental plan. The prior dental plan must have been in effect continuously for at least 12 months prior to the Effective Date of the Policy. All waiting periods will apply to future [Employees][and][Retirees]¹⁰¹.¹⁰²

Increasing Maximum Benefit – After the Policy has been in effect for 12 consecutive months, the Maximum [Contract][Calendar]¹⁰³ Year Benefit payable for each Insured Individual will increase by [\$200-\$500]¹⁰⁴ on the first day of the Policyholder's next [Contract][Calendar]¹⁰⁵ Year. The Maximum [Contract][Calendar]¹⁰⁶ Year Benefit will increase by the same amount for a maximum of [2-5]¹⁰⁷ increases.¹⁰⁸

108

SECTION 3 - DEFINITIONS

ACTIVE EMPLOYEE means an Employee who works for the Employer on a regular basis in the usual course of the Employer's business. The Employee must work the number of hours as defined in the Eligibility provision. 109

ACTIVE SERVICE means the performance in the customary manner by an Active Employee of all the regular duties of their employment with their Employer at one of the Employer's business establishments or at some location to which the Employer's business requires the Employee to travel. 110

ACTIVELY AT WORK means a day, which is one of the Employee's scheduled workdays if they are performing, in the usual way, all of the regular duties of their job. The Employee will be deemed to be Actively at Work on a day, which is not one of the Employees' scheduled workdays only if the Employee was Actively at Work on the preceding scheduled workday. 111

ADMINISTRATOR means an organization or entity that processes all or certain administrative functions for the Company.

ALLOWABLE CHARGE means the benefits according to a fee schedule that the Company and the Participating Provider have agreed upon. The Insured is responsible only for any Deductible amounts, the Coinsurance, and amounts in excess of any applicable maximum benefits.

For services rendered by a Non-Participating Provider, the Allowable Charge is the amount, determined by the Company, as developed from a statistically valid sample which (a) equitably recognizes geographic variations; (b) is updated periodically; and (c) is collected on the basis of current codes and descriptions developed and maintained by recognized authorities. 112

ALLOWABLE CHARGE means the amount, determined by the Company as developed from a statistically valid sample which (a) equitably recognizes geographic variations; (b) is updated periodically; and (c) is collected on the basis of current codes and descriptions developed and maintained by recognized authorities. 113

ALLOWABLE CHARGE means the benefits according to a fee schedule that the Company and the Participating Provider have agreed upon as the maximum fee for the Covered Expenses. The Insured is responsible only for any Deductible amounts, the Coinsurance, and amounts in excess of any applicable maximum benefits.

For services rendered by a Non-Participating Provider, the Allowable Charge is the amount, determined by the Company which is equivalent to the fee schedule that the Company and the Participating Providers have agreed upon as the maximum fee for the Covered Expenses. 114

BENEFIT WAITING PERIOD is a period of continuous coverage for an Insured Individual under the Policy, starting on their most recent Effective Date, during which expenses incurred for certain types of services are not covered. The lengths of all Benefit Waiting Periods, and the type of service to which they apply, are shown in the Schedule of Benefits and list of Covered Dental Expense Procedures. 115

CALENDAR YEAR means the 12-month period commencing on January 1st of a year and ending on December 31st of the same year. 116

CERTIFICATE means a document that describes the benefits provided to the Insured by the Policy.

CERTIFICATEHOLDER means the Employee who is eligible for benefits provided by the Policyholder's policy and who has been provided a Certificate of insurance.

COINSURANCE means the percentage of Covered Expenses that the Insured will pay once any Deductible is satisfied.

COMPANY is Companion Life Insurance Company. Our home office mailing address is [P.O. Box 100102, Columbia, SC 29202-3102.] 117

CONTRACT YEAR means the 12-month period starting on the Policy Anniversary Date of any year and ending at the end of the day before the Policy Anniversary Date of the following year. However, the first Contract Year starts on the Effective Date, and the last Contract Year ends on the termination date. 118

COVERED EXPENSES means services or treatment which are performed, prescribed, directed, or authorized by a Provider. To be considered Covered Expenses, services must be:

- 1) within the scope of the license of the Provider performing the service; and
- 2) incurred while coverage under this Certificate is in force; and
- 3) not specifically excluded or limited by the Certificate; and
- 4) listed as a covered procedure in the list of Covered Dental Expense Procedures.

DEDUCTIBLE means the amount of Covered Expenses that each Insured Individual must incur and is responsible to pay before any benefits are payable. This Deductible must be met during each [Calendar][Contract]¹¹⁹ Year.

DENTIST means a person who is licensed to practice dentistry or oral surgery and who is practicing within the scope of his or her license.

DEPENDENT means:

- 1) an Insured's Spouse; or
- 2) each Insured's Dependent Child under [26]¹²⁰ years of age; and
- 3) each unmarried child over [26]¹²¹ who is incapable of self-sustaining employment because of mental incapacity or physical handicap and primarily dependent on the Insured for support and maintenance.

Proof of the incapacity and dependency must be furnished upon request, to the Company within 31 days of the child's attainment of the limiting age and subsequently as may be required by Us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

DEPENDENT CHILD means:

- (a) the Insured's natural child from moment of birth;
- (b) the Insured's adopted child from the date of a final court order granting adoption of the child or, if earlier, the date the child is placed by a court in the Insured's home pending such an order;
- (c) any child living with the Insured in a regular parent-child relationship and primarily dependent on the Insured for support and maintenance, or
- (d) any child for whom We have notice, pursuant to a medical support order, that the Insured must provide support in the form of dental insurance from the date of such notice. For the purpose of this definition, "medical support order" is a valid order of a court, judicial department or government agency at the local, state, or federal level that obligates the Insured to provide a child financial support in the form of dental insurance.

EFFECTIVE DATE for the Employer means the first date coverage under the Policy becomes effective. The Effective Date is on the Policy cover page. The Effective Date for an Insured is shown on the Certificate. All insurance will begin at 12:01 A.M. standard time, at the Policyholder's address on the Effective Date. It will end at 12:01 A.M., standard time, at the Policyholder's address on the termination date.

ELIGIBILITY WAITING PERIOD means a period of continuous Active Service with an Employer that an Employee must serve in order to qualify for coverage under the Policy. The length of any Eligibility Waiting Period is shown on the Schedule of Benefits.

EMPLOYEE means a person permanently employed by the Employer for wages or salary and working for the Employer on a regular basis. [For purposes of this coverage, Employee includes a Non-Permanent Employee.]¹²²

EMPLOYER means the business organization listed on the Schedule of Benefits which provides dental insurance available through the Policy to its eligible Employees and has executed an application for dental insurance acceptable to Us.

FAMILY means an Insured and his or her Dependents.

FAMILY DEDUCTIBLE is met when the number of Insured Individuals as shown on the Schedule of Benefits separately meets the Deductible shown on the Schedule of Benefits. Once the Family Deductible is met, no additional Deductible will be required for other Insured Individuals [for the remainder of the [Contract][Calendar]¹²³ Year.]¹²⁴

125

FAMILY MEMBER means anyone related to an Insured Individual by blood, marriage, or adoption.

INSURED means a person who is an eligible [Employee][and][Retiree][Non-Permanent Employee]¹²⁶, who has qualified for insurance by completing the Eligibility Waiting Period, if any; as shown on the Schedule of Benefits and for whom coverage under the Policy has become effective.

INSURED INDIVIDUAL means the Insured and any Dependent covered under the Policy.

LATE ENTRANT means an Insured Individual whose Effective Date of Insurance is more than 31 days from the date the person qualifies for insurance, or who has elected to become insured again after the premium contribution is stopped for reasons other than loss of eligibility for insurance. ¹²⁷

LIFETIME DEDUCTIBLE the amount of Covered Expenses that each Insured Individual must incur and is responsible to pay before any benefits are payable. This deductible must be met only once during the Insured Individual's lifetime. ¹²⁸

MAXIMUM [CONTRACT][CALENDAR]¹²⁹ YEAR BENEFIT means the maximum amount the Company will pay on behalf of any Insured Individual per [Contract][Calendar]¹³⁰ Year.

MEDICALLY NECESSARY means services needed to treat, correct, or ameliorate a medical defect or condition as part of an essential part of an overall treatment plan developed by both the Physician and the Provider in consultation with each other. Establishment of medical necessity requires documentation to support the severe handicapping malocclusion and the presence of a qualifying medical condition.

NON-PERMANENT EMPLOYEE means those who perform services for the Employer for compensation and may include, but are not limited to, those compensated on a 1099 basis, seasonal workers or board members. ¹³¹

NON-PARTICIPATING PROVIDER means a Provider who has not agreed to provide services as a Participating Provider. ¹³²

PARTICIPATING PROVIDER means a Provider who agrees to provide services at a discounted fee pursuant to a written agreement. ¹³³

PHYSICIAN means any person who is licensed by the law of the state in which treatment, within the scope of his or her license, is given for sickness or injury causing the expenses or loss for which claim is made.

POLICY means the contract of insurance made by the Company and the Policyholder.

POLICY ANNIVERSARY DATE means the date established and agreed to by the Policyholder and Us from which Policy months, years, and anniversaries are computed.

POLICYHOLDER means the firm or other organization to which the Policy is issued. The term Policyholder will also include those subsidiaries, divisions, and affiliates listed in the Policy.

PREVIOUS POLICY means the policy issued to the Policyholder by the previous insurer that is replaced by this coverage on the Policy Effective Date. ¹³⁴

PROVIDER means a healthcare professional who is professionally licensed by the appropriate state agency and who provides services within the scope of that license. A Provider's services are not covered if the Provider resides in the Insured's home or is a Family Member.

RETIREE means a former Active Employee of the Employer that has retired. ¹³⁵

SCHEDULE OF BENEFITS means the document showing the eligible class, the amounts of insurance, and other relevant information about the plan of insurance applied for by the Employer under the Policy. It is made a part of the Policy for the purposes of defining Employer coverage under the Policy.

SPOUSE means a lawfully recognized partner of the Insured, who is not a relative, is of legal age, is not currently married to someone else, is in a committed relationship with the Insured and shares financial obligations and can provide legal proof of marriage. Spouse also includes the Insured's domestic partner or civil union partner as defined by state law. The Insured must provide the [Policyholder][and] [Company]¹³⁶ with proof of such legal domestic partnership or legal civil union

partnership required by state law or the Company including as applicable, but not limited to, a declaration of such partnership, license of such partnership or registration of such partnership, or other documentation as required by state law.

YOU, YOUR, YOURS means the Insured.

WE, US, and OUR means Companion Life Insurance Company or its Administrator.

SECTION 4 - ELIGIBILITY AND ENROLLMENT

Eligible Employee means You

- | | |
|--|-----|
| 1) are an Active Employee working [5-1,560] ¹³⁷ hours or more [per week][per year] ¹³⁸ who is a legal resident or citizen of the U.S.; and | 139 |
| 2) qualify as an eligible Employee as shown in the Schedule of Benefits [; or] ¹⁴⁰ [.] ¹⁴¹ | |
| 3) are a Retiree of the Employer. [;or] | 142 |
| 4) are a Non-Permanent Employee. | 143 |

Eligible Dependents include

- 1) an Insured's Spouse; and/or
- 2) each Insured's Dependent Child under [26]¹⁴⁴ years of age.
- 3) each unmarried child over [26]¹⁴⁵ years of age who is incapable of self-sustaining employment because of mental incapacity or physical handicap and primarily dependent on the Insured for support and maintenance.

Proof of the incapacity and dependency must be furnished upon request, to the Company within 31 days of the child's attainment of the limiting age and subsequently as may be required by Us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

No one can be insured as a Dependent of more than one eligible [Employee][or][Retiree]¹⁴⁶.

No one on active duty in the armed forces of any country can be insured as a Dependent.

No one can be insured as a Dependent if eligible for insurance as an eligible [Employee][or][Retiree].¹⁴⁷

If both the eligible [Employee][or][Retiree]¹⁴⁸ and Spouse are eligible [Employees][or][Retirees]¹⁴⁹ of the Policyholder, only one of them may insure the Dependent Child for dental care expenses.

150

Dependents acquired after coverage is effective

All Dependents except for newborn children will be covered from the date they meet the definition of Dependent if written request and payment of any required premium is submitted within 31 days. Newborn children will be covered from the moment of birth for a period of 31 days. To continue coverage beyond 31 days, written request and payment of any required premium must be submitted within such 31-day period.

151

Retiree

An Insured who is age 55 or older who retires may continue coverage under the Policy subject to the following:

- 1) the Policyholder must certify that the Insured has voluntarily terminated employment;
- 2) benefits and premium shall be the same as for any similarly situated Active Employee;
- 3) the Policy has not terminated in accordance with the Termination of Insurance provision;

Dependent coverage may be continued so long as Retiree coverage remains in force.

152

Non-Permanent Employee

A Non-Permanent Employee means those who perform services for the Employer for compensation and may include, but are not limited to, those compensated on a 1099 basis, seasonal workers, or board members. Eligibility is determined by the Policyholder and agreed to by Us.

153

Eligibility Waiting Period

Employees are eligible under this Certificate after completing the Eligibility Waiting Period as described on the Schedule of Benefits, if any, as established by the Policyholder.

An Insured whose eligibility terminates and is established again within [1-24]¹⁵⁴ month(s) will not have to complete a new Eligibility Waiting Period before becoming eligible for coverage.

If We receive an eligible Employee's enrollment more than the 31 days after completing any Eligibility Waiting Period, they will be considered a Late Entrant. An additional Benefit Waiting Period as shown on the Schedule of Benefits may apply to Late Entrants.

155

Enrollment if a Section 125 Plan

If the Policy is provided as part of the Employer's Section 125 Plan, each eligible Employee has the option under the Section 125 Plan of participating or not participating in the Policy. If an eligible Employee does not elect to participate when initially eligible, the eligible Employee may elect to participate at a subsequent election period. This election period will be held each year and those who elect to participate in the Policy at that time will have their insurance become effective on [Not Applicable or Jan. 1st- Dec. 31st]¹⁵⁶. An eligible Employee who elects to participate during the election period who did not elect to participate when initially eligible will be considered a Late Entrant and is subject to the waiting periods associated with the Policy. Eligible Employees may change their election option only during the election period, except for a change in family status. Family status changes would be marriage, divorce, birth of a child, death of a Spouse/child, or termination of employment of a Spouse.

Eligible Employee Effective Date

The Effective Date for an eligible Employee covered by the Policy, subject to payment of the required premium and satisfaction of the waiting period, will be the later of:

- 1) the Effective Date of the Policy if We receive the eligible Employee request for coverage prior to the Effective Date; or
- 2) [[1st-31st]¹⁵⁷ day of the month] ¹⁵⁸after We receive the eligible Employee request for coverage if that date is after the date they have met the qualifications of an eligible Employee.

Eligible Employees must be Actively at Work on the Effective Date for coverage, or any increase in coverage to take effect. If not, the coverage or increase in coverage will take effect when the eligible Employee returns to work and meets the definition of Actively at Work.

159

Benefit Classification Change

If an Insured's status changes so they become an eligible Employee of a different class, as shown in the Schedule of Benefits, any change in amounts of insurance because of the new class will take effect on the [1st][15th]¹⁶⁰ of the month [or immediately following the change]¹⁶¹.

Eligible Dependent Effective Date

The Effective Date for each eligible Dependent covered by the Policy except for newborn children will be the first day of the month after:

- 1) the Company's acceptance of the signed request for coverage that includes Dependent coverage; and
- 2) receipt of the first premium.

However, if on such date the coverage for the eligible Employee has not yet taken effect, the Effective Date for Dependent coverage will be the same as the Effective Date for such eligible Employee.

The Effective Date for each eligible Dependent who is a newborn child covered by the Policy will be the date of birth and will continue for a period of 31 days. Coverage will continue to be effective beyond 31 days provided written request and payment of any required premium is submitted within such 31-day period.

SECTION 5 - TERMINATION/NONRENEWAL/CONTINUATION

Termination of Insurance

The Insured's insurance provided under the Policy will terminate at 12:01A.M., standard time, at the Policyholder's address on the earliest of the following:

- 1) the date the Policy terminates;
- 2) the date the Policy is amended or changed to exclude coverage for the class of eligible individuals to which the Insured belongs;
- 3) the date that the Insured ceases to be a member of the classes for whom insurance is provided;
- 4) the end of the period for which any required contribution is made, or as negotiated by Us and the Policyholder;
- 5) the date on which an Insured Individual enters the armed forces, other than for reserve duty of 30 days or less.

The Dependent's insurance provided under the Policy will terminate at 12:01A.M., standard time, at the Policyholder's address on the earliest of the following:

- 1) the date the Policy terminates;
- 2) the date the Insured's coverage terminates;
- 3) the date We are notified to terminate the Dependent's coverage;
- 4) the date that the Dependent ceases to qualify as an eligible Dependent;
- 5) the end of the period for which any required contribution is made, or as negotiated by Us and the Policyholder;
- 6) the date on which an Insured Individual enters the armed forces, other than for reserve duty of 30 days or less.

Continuation of Coverage

The Policyholder may, but is not required to, consider Employees as eligible Employees and continue insurance even though they are:

- 1) temporarily laid-off and the Policyholder expects to call them back to work;
- 2) put on approved leave of absence; or
- 3) unable to work because of injury or sickness.

The Policyholder must treat all Insureds the same for purposes of continuing insurance. If insurance is so continued, it will end on the earliest of:

- 1) the date the Policyholder notifies the Company that the Insured is no longer a member of an eligible class; or
- the date that ends the period for which the Policyholder last paid the premium for the Insured and their Dependents.

162

Any Insured Individual has the right to continue their coverage for a limited time after it would otherwise terminate. Below explains certain instances when an Insured Individual's coverage may be continued. Please contact the Policyholder's benefits Administrator for additional information. If insurance is continued, it must be according to a plan which does not allow individual selection.

COBRA Continuation Rights

If coverage for an Insured Individual ends, they may qualify for continuation of such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, amended (COBRA). For more information, contact the Policyholder's benefits Administrator. The following groups are not subject to this regulation:

- 1) groups of less than 20 Employees; or
- 2) certain church plans.

Death or Divorce – For Dependents Only

The Insured's Spouse may continue coverage under the Policy if the Insured dies or the marriage is dissolved provided the Spouse makes an election to continue coverage within [30-90]¹⁶³ days of such occurrence and premium is paid within [30-90]¹⁶⁴ days of notification of continuation. Coverage may include any Dependent Child whose insurance would end at the same time.

Coverage will terminate under continuation due to death or divorce on the earliest of:

- 1) the last day of the period for which the premium is paid;
- 2) the date coverage would normally stop under the terms of the Policy, except coverage must not be changed or stopped during the first [60-365]¹⁶⁵ days of continuation unless coverage is changed or stopped for all Employees covered under the Policy;
- 3) the date the Spouse becomes insured under another group health plan;
- 4) the date the Spouse remarries;
- 5) the date coverage has been continued for [2-3]¹⁶⁶ years, for Spouse under age [50-65]¹⁶⁷ when continuation started;

- 6) the date the Spouse or Dependent Child is eligible for coverage under Medicare, Title XVIII of the Federal Social Security Act; or
- 7) the date the Policy terminates.

SECTION 6 - BENEFITS/COVERAGE

The Company will pay the percentage payable as shown on the Schedule of Benefits for charges incurred during each [Contract][Calendar]¹⁶⁸ Year after the Deductible, if any, has been met for all services listed in the Covered Dental Expense Procedures when Covered Expenses are incurred.

If an Insured Individual transfers from the care of one Provider to another Provider during the course of treatment, or if more than one Provider renders services, benefits are not payable for more than the amount that would have been covered if one Provider rendered the service or services.

The Company may request pre-operative dental x-rays to determine liability for procedures submitted. If x-rays are not provided, We will decide on the benefits for the procedure that would result in a professionally adequate restoration, replacement, or treatment.

Unless We agree otherwise, Covered Expenses will include only charges for services listed in the Covered Dental Expense Procedures. If a non-listed procedure is accepted, We will determine the amount payable from a list of procedures of comparable nature.

Predetermination of Benefits

Predetermination of dental benefits is a service available through the Policy. This benefit review in advance of treatment enables an Insured Individual and their Provider to see what services are covered by the Policy. Ask Your Provider to submit a predetermination request. The Company will then provide a Predetermination of Benefits and payable amounts.

Please note the service is not designed to be used for emergency treatments or routine preventive services such as exams, x-rays, or cleaning.

Deductible

The Deductible, if applicable, is the amount of Covered Expenses that each Insured Individual must incur and is responsible to pay before any benefits are payable. The Deductible must be met from Covered Expenses incurred during each timeframe as outlined in the Schedule of Benefits and from the types of covered dental expenses to which it applies. The Deductible applies separately to the Covered Expenses incurred by each Insured Individual.

Family Deductible

The Family Deductible, if any, is met when the number of Insured Individuals as shown on the Schedule of Benefits separately meets the Deductible shown on the Schedule of Benefits. Once the Family Deductible is met, no additional Deductible will be required for other Insured Individuals [for the remainder of the [Contract][Calendar]¹⁶⁹ Year.]¹⁷⁰ 171

Lifetime Deductible

The amount of Covered Expenses that each Insured Individual must incur and is responsible to pay before any benefits are payable. This deductible must be met only once during the Insured Individual's lifetime. 172

Benefit Waiting Period

The Company will not pay for, and Covered Expenses do not include, charges incurred by an Insured Individual before the Benefit Waiting Period, if any, is satisfied. 173

Alternative Procedures

If two or more procedures are adequate and appropriate treatment to correct a certain condition, the amount of the Covered Expense will be the allowance for the least expensive procedure. The Insured Individual may be responsible for the difference.

We may ask that pre-operative dental x-rays be given to Us to decide if We are liable for the procedures submitted for consideration. If the x-rays are not given, We will decide the procedures which would provide professionally adequate restoration, replacement, or treatment. If We then receive the pre-operative dental x-rays and decide that different procedures are more appropriate, We will make adjustments that We deem are proper.

Start Date for Procedures

For a denture, partial denture, or other appliance or a change to any appliance, other than a fixed bridge, the procedure starts at the time the impression is made. For a fixed bridge or a crown, inlay, onlay, or other precious or semiprecious metal restoration, the procedure starts at the time the tooth or teeth are prepared. For root canal therapy, the procedure starts at the time the pulp chamber is opened. For any other procedure requiring more than one session to complete, the procedure starts at the time of the first session. For any procedure requiring only one session to complete, the procedure starts at the time the service is rendered or the supply is furnished.

Incurred Date for Expenses

For a denture, partial denture, implant, fixed bridge, other appliance, crown, inlay, onlay, or other precious or semiprecious metal restoration whether the item is new, replacement, repaired, or modified, the expense is incurred at the time of final placement of the item. For root canal therapy, the expense is incurred at the time the root canal is completed. For any other procedure requiring more than one session to complete, the expense is incurred at the time the last session is completed. For any procedure requiring only one session to complete the expense is incurred at the time the service is rendered or the supply is furnished.

COVERED DENTAL EXPENSE PROCEDURES

The following is a complete list of the dental procedures for which benefits are payable under this section. No benefits are payable for a procedure that is not listed.

Proc. Description of Service No.

[Class I – Preventive Services; Class II – Basic Services; Class III – Major Services]

Diagnostic and Preventive

- D0120 – Periodic oral evaluation
- D0140 – Limited oral evaluation – problem focused
- D0145 – Oral evaluation for a patient under three years of age and counseling with primary caregiver
- D0150 – Comprehensive oral evaluation
- D0160 – Detailed and extensive oral evaluation – problem focused, by report
- D0170 – Re-evaluation – limited, problem focused (established patient; not post op visit)
- D0180 – Oral examination, comprehensive periodontal evaluation
- D0210 – Intraoral–complete series (including bitewings)
- D0230 – Intraoral–periapical each additional film
- D0240 – Intraoral–occlusal film
- D0250 – Extraoral – first film
- D0270 – Bitewing – single film
- D0272 – Bitewings – two films
- D0273 – Bitewings – three films
- D0274 – Bitewings – four films
- D0277 – Bitewing, vertical, 7 to 8 films
- D0330 – Panoramic Film
- D0460 – Pulp vitality tests
- D0470 – Diagnostic Models
- D1110 – Prophylaxis – adult
- D1120 – Prophylaxis – child
- D1208 – Topical application of fluoride (prophylaxis not included)
- D1206 – Topical fluoride varnish (Under age 19)
- D1351 – Sealant – per tooth – unrestored permanent molars (under age 19)
- D1352 – Preventative resin restorations in a moderate to high caries risk patient – permanent tooth
- D1353 – Sealant repair – per tooth
- D1510 – Space maintainer – fixed – unilateral
- D1516 – Space maintainer – fixed – bilateral, maxillary
- D1517 – Space maintainer – fixed – bilateral, mandibular
- D1520 – Space maintainer – removable – unilateral
- D1525 – Space maintainer – removable – bilateral
- D1526 – Space maintainer – removable – bilateral, maxillary
- D1527 – Space maintainer – removable – bilateral, mandibular
- D1550 – Re-cementation of space maintainer
- D1555 – Removal of fixed space maintainer (not by Dentist who placed appliance)
- D1575 – Distal shoe space maintainer – fixed – unilateral
- D9110 – Palliative (emergency) treatment of dental pain – minor procedure
- D9310 – Consultation (diagnostic service provided by Dentist or Physician other than practitioner providing treatment)

Minor Restorative Services (local anesthesia is considered to be part of restorative procedures)

- D2140 – Amalgam – one surface, primary or permanent

D2150 – Amalgam – two surfaces, primary or permanent
 D2160 – Amalgam – three surfaces, primary or permanent
 D2161 – Amalgam – four or more surfaces, primary or permanent
 D2330 – Resin-based composite – one surface, anterior
 D2331 – Resin-based composite – two surfaces, anterior
 D2332 – Resin-based composite – three surfaces, anterior
 D2335 – Resin-based composite – four or more surfaces or involving incisal angle (anterior)
 D2390 – Resin-based composite crown, anterior
 D2391 – Composite – one surface, primary or permanent
 D2392 – Composite – two surface, primary or permanent
 D2393 – Composite – three surface, primary or permanent
 D2394 – Composite – four surface, primary or permanent
 D2940 – Protective restoration

Major Restorative Services

D2410 – Gold foil – one surface
 D2420 – Gold foil – two surface
 D2430 – Gold foil – three surface
 D2510 – Inlay – metallic – one surface – An alternate benefit will be provided
 D2520 – Inlay – metallic – two surfaces – An alternate benefit will be provided
 D2530 – Inlay – Three surfaces – An alternate benefit will be provided
 D2542 – Onlay – metallic – two surfaces
 D2543 – Onlay – metallic – three surfaces
 D2544 – Onlay – metallic – four or more surfaces
 D2610 – Inlay – porcelain/ceramic – one surface
 D2620 – Inlay – porcelain/ceramic – two surfaces
 D2630 – Inlay – porcelain/ceramic – three surfaces
 D2642 – Onlay – porcelain/ceramic – two surfaces
 D2643 – Onlay – porcelain/ceramic – three surfaces
 D2644 – Onlay – porcelain/ceramic – four or more surfaces
 D2650 – Inlay – resin-based composite – one surface
 D2651 – Inlay – resin-based composite – two surfaces
 D2652 – Inlay – resin-based composite – three or more surfaces
 D2662 – Onlay – resin base composite – two surfaces
 D2663 – Onlay – resin base composite – three surfaces
 D2664 – Onlay – resin base composite – four or more surfaces
 D2710 – Crown – resin-based composite (indirect)
 D2712 – Crown – 3/4 resin-based composite (indirect)
 D2720 – Crown – resin with high noble metal
 D2721 – Crown – resin with predominately base metal
 D2722 – Crown – resin with noble metal
 D2740 – Crown – porcelain/ceramic
 D2750 – Crown – porcelain fused to high noble metal
 D2751 – Crown – porcelain fused to predominantly base metal
 D2752 – Crown – porcelain fused to noble metal
 D2780 – Crown – 3/4 cast high noble metal
 D2781 – Crown – 3/4 cast predominantly base metal
 D2782 – Crown – 3/4 cast noble metal

D2783 – Crown – 3/4 porcelain/ceramic (This code does not include facial veneers)
 D2790 – Crown – full cast high noble metal
 D2791 – Crown – full cast predominantly base metal
 D2792 – Crown – full cast noble metal
 D2794 – Crown – titanium
 D2910 – Recement inlay, only or partial coverage restoration
 D2915 – Recement cast or prefabricated post and core
 D2920 – Recement crown
 D2930 – Prefabricated stainless-steel crown – primary tooth
 D2931 – Prefabricated stainless-steel crown – permanent tooth
 D2932 – Prefabricated resin crown
 D2933 – Prefabricated stainless-steel crown with a resin window
 D2934 – Prefabricated esthetic coated stainless steel-crown – primary tooth
 D2950 – Core buildup, including pins
 D2951 – Pin retention – Per tooth – in addition to restoration
 D2953 – Each additional cast post – same tooth
 D2954 – Prefabricated post and core in addition to crown
 D2955 – Post removal (not in conjunction with endodontic therapy)
 D2957 – Each additional prefabricated post – same tooth
 D2971 – Additional procedures to construct new crown under existing partial denture framework
 D2980 – Crown repair, by report
 D2981 – Inlay repair
 D2982 – Onlay repair

Endodontic Services

D3110 – Anterior (excluding final restoration)
 D3120 – Bicuspid (excluding final restoration)
 D3220 – Therapeutic pulpotomy premolar (excluding final restoration)
 D3221 – Pulpal debridement
 D3222 – Partial pulpotomy for apexogenesis
 D3230 – Pulpal therapy (resorbable filling – anterior, primary tooth (excludes final restoration)
 D3240 – Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)
 D3310 – Endodontic therapy, anterior tooth, (excluding final restoration)
 D3320 – Endodontic therapy, premolar (excluding final restoration)
 D3330 – Endodontic therapy molar (excluding final restoration)
 D3331 – Treatment of root canal obstruction – non-surgical access
 D3332 – Incomplete endodontic therapy – inoperable, unrestorable or fractured tooth
 D3333 – Internal root repair of perforation defects
 D3346 – Retreatment of previous root canal therapy – anterior
 D3347 – Retreatment of previous root canal therapy – bicuspid
 D3348 – Retreatment of previous root canal therapy – molar
 D3351 – Apexification/recalcification – initial visit (apical closure/calcific repair or perforations, root resorptions)
 D3352 – Apexification/recalcification – interim visit (apical closure/calcific repair or perforations, root resorptions)
 D3353 – Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair or perforations, root resorptions, etc.)
 D3355 – Pulpal regeneration – initial visit
 D3356 – Pulpal regeneration – interim medication replacement
 D3357 – Pulpal regeneration – completion of treatment
 D3410 – Apicoectomy/periradicular surgery – anterior

D3421 – Apicoectomy/periradicular surgery – premolar (first root)
 D3425 – Apicoectomy/periradicular surgery – molar (first root)
 D3426 – Apicoectomy/periradicular surgery – (each additional root)
 D3427 – Periarticular surgery without apicoectomy
 D3428 – Bone graft in conjunction with periradicular surgery – per tooth, single site
 D3429 – Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site
 D3430 – Retrograde filling – per root
 D3432 – Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery
 D3450 – Root amputation – per root
 D3460 – Endodontic endosseous implant
 D3470 – Intentional re-implantation (including necessary splinting)
 D3920 – Hemisection (including any root removal), not including root canal therapy

Periodontic Services

D4210 – Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant
 D4211 – Gingivectomy or gingivoplasty – one to three teeth
 D4212 – Gingivectomy or gingivoplasty – with restorative procedures, per tooth
 D4240 – Gingival flap procedure, four or more teeth
 D4241 – Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth or bounded teeth spaces per quadrant
 D4245 – Apically positioned flap
 D4249 – Clinical crown lengthening – hard tissue
 D4260 – Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant
 D4261 – Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant
 D4263 – Bone replacement graft – first site in quadrant
 D4264 – Bone replacement graft – retained natural tooth – each additional site in quadrant
 D4265 – Biologic materials to aid in soft and osseous tissue regeneration
 D4266 – Guided tissue regeneration – resorbable barrier, per site
 D4267 – Guided tissue regeneration – non-resorbable barrier, per site
 D4268 – Surgical revision procedure, per tooth
 D4270 – Pedicle soft tissue graft procedure
 D4273 – Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft site.
 D4274 – Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)
 D4275 – Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft site.
 D4276 – Combined connective tissue and double pedicle graft, per tooth
 D4277 – Free soft tissue graft (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft
 D4278 – Free soft tissue graft (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in graft additional teeth
 D4283 – Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant, or edentulous tooth position in the same graft site.
 D4285 – Non-autogenous connective tissue graft (including recipient site and donor material) each additional contiguous tooth, implant, or edentulous tooth position in graft site.
 D4320 – Provisional splinting – intracoronal
 D4321 – Provisional splinting – extracoronal
 D4341 – Periodontal scaling and root planing, four or more teeth per quadrant.
 D4342 – Periodontal scaling and root planing, one to three teeth, per quadrant.
 D4346 – Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
 D4355 – Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit

D4381 – Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910 – Periodontal maintenance procedures (following active therapy)
D5994 – Periodontal medicament carrier with peripheral seal – laboratory processed

Prosthodontic Services

D5110 – Complete denture – maxillary
D5120 – Complete denture – mandibular
D5130 – Immediate denture – maxillary
D5140 – Immediate denture – mandibular
D5211 – Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5212 – Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5213 – Maxillary partial denture – cast metal framework – resin denture base (including any conventional clasps, rests and teeth)
D5214 – Mandibular partial denture – cast metal framework – resin denture base (including any conventional clasps, rests and teeth)
D5221 – Immediate maxillary partial denture – resin base (including any conventional clasps, rest, and teeth)
D5222 – Immediate mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)
D5223 – Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)
D5224 – Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)
D5225 – Maxillary partial denture – flexible base (including any clasps, rests and teeth)
D5226 – Mandibular partial denture – flexible base (including any clasps, rests, and teeth)
D5282 – Removable unilateral partial denture – one-piece cast metal (including clasps and teeth), maxillary
D5283 – Removable unilateral partial denture – one-piece cast metal (including clasps and teeth), mandibular

Prosthodontic – Relines and Repairs

D5410 – Adjust complete denture – maxillary
D5411 – Adjust complete denture – mandibular
D5421 – Adjust partial denture – maxillary
D5422 – Adjust partial denture – mandibular – repair broken complete denture base
D5511 – Repair broken complete denture base, mandibular
D5512 – Repair broken complete denture base, maxillary
D5520 – Replace missing or broken teeth – complete denture (each tooth)
D5611 – Repair resin partial denture base, mandibular
D5612 – Repair resin partial denture base, maxillary
D5621 – Repair cast partial framework, mandibular
D5622 – Repair cast partial framework, maxillary
D5630 – Repair or replace broken clasp
D5640 – Replace broken teeth – per tooth
D5650 – Add tooth to existing partial denture
D5660 – Add clasp to existing partial denture
D5670 – Replace all teeth and acrylic on cast metal framework (maxillary)
D5671 – Replace all teeth and acrylic on cast metal framework (mandibular)
D5710 – Rebase complete maxillary denture (upper)
D5711 – Rebase complete mandibular denture
D5720 – Rebase maxillary partial denture (upper)
D5721 – Rebase mandibular partial denture (lower)
D5730 – Reline complete maxillary denture (upper)
D5731 – Reline complete mandibular denture (lower)
D5740 – Reline maxillary partial denture (lower)

D5741 – Reline mandibular partial denture (lower)
 D5750 – Reline complete maxillary denture (laboratory) (upper)
 D5751 – Reline complete mandibular denture (laboratory) (lower)
 D5760 – Reline maxillary partial denture (laboratory) (upper)
 D5761 – Reline mandibular partial denture (laboratory) (lower)
 D5863 – Overdenture – complete maxillary
 D5864 – Overdenture – partial maxillary
 D5865 – Overdenture – complete mandibular
 D5866 – Overdenture – partial mandibular
 D5876 – Add metal substructure to acrylic full denture (per arch)
 D6930 – Recement fixed partial denture
 D6940 – Stress breaker
 D6980 – Fixed partial denture repair by report
 D6985 – Pediatric partial denture, fixed

Implants Services

D6010 – Endosteal implant
 D6013 – Surgical placement of mini implant
 D6040 – Eposteal implant
 D6050 – Transosteal implant, including hardware
 D6055 – Connecting bar – implant or abutment supported
 D6056 – Prefabricated abutment
 D6057 – Custom abutment
 D6058 – Abutment supported porcelain ceramic crown
 D6059 – Abutment supported porcelain fused to high noble metal
 D6060 – Abutment supported porcelain fused to predominately base metal crown
 D6061 – Abutment supported porcelain fused to noble metal crown (1x/60 months)
 D6062 – Abutment supported cast high noble metal crown
 D6063 – Abutment supported cast predominately base metal crown
 D6064 – Abutment supported cast noble metal crown
 D6065 – Implant supported porcelain/ceramic crown
 D6066 – Implant supported porcelain fused to high metal crown
 D6067 – Implant supported metal crown
 D6068 – Abutment supported retainer for porcelain/ceramic fixed partial denture
 D6069 – Abutment supported retainer for porcelain fused to high noble metal fixed partial denture
 D6070 – Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture
 D6071 – Abutment supported retainer for porcelain fused to noble metal fixed partial denture
 D6072 – Abutment supported retainer for cast high noble metal fixed partial denture
 D6073 – Abutment supported retainer for predominately base metal fixed partial denture
 D6074 – Abutment supported retainer for cast noble metal fixed partial denture
 D6075 – Implant supported retainer for ceramic fixed partial denture
 D6076 – Implant supported retainer for porcelain fused to high noble metal fixed partial denture
 D6077 – Implant supported retainer for cast metal fixed partial denture
 D6080 – Implant maintenance procedures
 D6081 – Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
 D6096 – Remove broken implant retaining screw
 D6100 – Implant removal
 D6101 – Debridement peri-implant defect, covered if implants are covered

D6102 – Debridement and osseous peri-implant defect, covered if implants covered
 D6103 – Bone graft peri-implant defect, covered if implants covered
 D6104 – Bone graft implant replacement, covered if implants covered
 D6110 – Implant/abutment support removable denture for edentulous arch – maxillary
 D6111 – Implant/abutment support removable denture for edentulous arch – mandibular
 D6112 – Implant/abutment supported removable denture for partially edentulous arch – maxillary
 D6113 – Implant/abutment supported removable denture for partially edentulous arch – mandibular
 D6114 – Implant/abutment supported fixed denture for edentulous arch – maxillary
 D6115 – Implant/abutment supported fixed denture for edentulous arch – mandibular
 D6116 – Implant/abutment supported fixed denture for partially edentulous arch – maxillary
 D6117 – Implant/abutment supported fixed denture for partially edentulous arch – mandibular
 D6190 – Implant index
 D6194 – Abutment supported retainer crown for FPD (titanium)
 D6205 – Pontic – indirect resin-based composite
 D6210 – Pontic – cast high noble metal
 D6211 – Pontic – cast predominantly base metal
 D6212 – Pontic – cast noble metal
 D6214 – Pontic – titanium
 D6240 – Pontic – porcelain fused to high noble metal
 D6241 – Pontic – porcelain fused to predominantly base metal
 D6242 – Pontic – porcelain fused to noble metal
 D6245 – Pontic – porcelain/ceramic
 D6545 – Retainer – cast metal for resin bonded fixed prosthesis
 D6548 – Retainer – porcelain/ceramic for resin bonded fixed prosthesis
 D6549 – Resin retainer – for resin bonded fixed prosthesis
 D6600 – Retainer inlay – porcelain/ceramic, two surfaces
 D6601 – Retainer inlay – porcelain/ceramic, three or more surfaces
 D6602 – Cast high noble metal, two surfaces
 D6603 – Cast high noble metal, three or more surfaces
 D6604 – Cast predominantly base metal, two surfaces
 D6605 – Cast predominantly base metal, three or more surfaces
 D6606 – Cast noble metal, two surfaces
 D6607 – Cast noble metal, three or more surfaces
 D6608 – Retainer onlay – porcelain/ceramic, two surfaces
 D6609 – Retainer onlay – porcelain/ceramic, three or more surfaces
 D6610 – Retainer onlay – cast high noble metal, two services
 D6611 – Retainer onlay – cast high noble metal, three or more surfaces
 D6612 – Retainer onlay – cast predominantly base metal, two surfaces
 D6613 – Retainer onlay – cast predominantly base metal, three or more surfaces
 D6614 – Retainer onlay – cast noble metal, two surfaces
 D6615 – Retainer onlay – cast noble metal, three or more surfaces
 D6624 – Retainer inlay – titanium
 D6634 – Retainer onlay – titanium
 D6710 – Retainer crown – indirect resin-based composite
 D6720 – Retainer crown – resin with high noble metal
 D6721 – Retainer crown – resin with predominantly base metal
 D6722 – Retainer crown – resin with noble metal
 D6740 – Crown – porcelain/ceramic

D6750 – Crown – porcelain fused to high noble metal
 D6751 – Crown – porcelain fused to predominantly base metal
 D6752 – Crown – porcelain fused to noble metal
 D6780 – Crown – 3/4 cast high noble metal
 D6781 – Crown – 3/4 cast predominantly base metal
 D6782 – Crown – 3/4 cast noble metal
 D6783 – Crown – 3/4 porcelain/ceramic
 D6790 – Crown – full cast high noble metal
 D6791 – Crown – full cast predominantly base metal
 D6792 – Crown – full cast noble metal
 D6794 – Retainer crown – titanium

Oral Surgery Services

D7111 – Extraction, coronal remnants – primary tooth
 D7140 – Extraction, erupted tooth or exposed root (elevation and/or forceps removal).
 D7210 – Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
 D7220 – Removal of impacted tooth – soft tissue
 D7230 – Removal of impacted tooth – partial bony
 D7240 – Removal of impacted tooth – completely bony
 D7241 – Removal of impacted tooth – completely bony, with unusual surgical complications
 D7250 – Surgical removal of residual tooth roots (cutting procedure)
 D7251 – Coronectomy – intentional partial tooth removal
 D7270 – Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
 D7272 – Tooth transplantation (include reimplantation from one site to another and splinting and/or stabilization)
 D7280 – Surgical access of an unerupted tooth
 D7282 – Mobilization of erupted or malposition tooth to aid eruption
 D7283 – Placement of device to facilitate eruption of impacted tooth
 D7285 – Incisional biopsy of oral tissue – hard (bone, tooth)
 D7286 – Biopsy of oral tissue – soft
 D7287 – Exfoliative cytological sample collection
 D7288 – Brush biopsy – transepithelial sample collection
 D7290 – Surgical repositioning of teeth
 D7291 – Transseptal fiberotomy/supra crestal fiberotomy, by report
 D7310 – Alveoloplasty in conjunction with extractions – per quadrant
 D7311 – Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
 D7320 – Alveoloplasty not in conjunction with extractions – per quadrant
 D7321 – Alveoloplasty, not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
 D7340 – Vestibuloplasty – ridge extension (secondary epithelialization)
 D7350 – Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
 D7410 – Excision of benign lesion up to 1.25 cm
 D7411 – Excision of benign lesion greater than 1.25 cm
 D7412 – Excision of benign lesion complicated
 D7413 – Excision of malignant lesion up to 1.25 cm
 D7414 – Excision of malignant lesion greater than 1.25 cm
 D7415 – Excision of malignant lesion, complicated
 D7440 – Excision of malignant tumor – lesion diameter up to 1.25 cm
 D7441 – Excision of malignant tumor – lesion diameter greater than 1.25 cm

D7450 – Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
 D7451 – Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
 D7460 – Removal of benign non-odontogenic cyst or tumor – lesion diameter up to 1.25 cm
 D7461 – Removal of benign non-odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
 D7465 – Destruction of lesion by physical or chemical by report
 D7472 – Removal of torus palatinus
 D7473 – Removal of torus mandibularis
 D7510 – Incision and drainage of abscess – intraoral soft tissue
 D7511 – Incision and drainage of abscess – intraoral soft tissue – complicated
 D7520 – Incision and drainage of abscess – extraoral soft tissue
 D7521 – Incision and drainage of abscess – extraoral soft tissue – complicated
 D7950 – Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla
 D7953 – Bone replacement graft for ridge preservation – per site
 D7960 – Frenulectomy (frenectomy or frenotomy) – separate procedure
 D7963 – Frenuloplasty
 D7970 – Excision of hyperplastic tissue – per arch
 D7971 – Excision of pericoronal gingiva
 D7972 – Surgical reduction of fibrous tuberosity
 D7971 – Excision of pericoronal gingiva

Anesthesia

D9222 – Deep sedation/general anesthesia – first 15 minutes
 D9223 – Deep sedation/general anesthesia – each additional 15 minutes
 D9239 – Intravenous conscious sedation/anesthesia – first 15 minutes
 D9243 – Intravenous conscious sedation/anesthesia – each additional 15 minutes]¹⁷⁴

Class IV Orthodontia Services

D8010 – Limited orthodontic treatment of the primary dentition
 D8020 – Limited orthodontic treatment of the transitional dentition
 D8030 – Limited orthodontic treatment of the adolescent dentition
 D8040 – Limited orthodontic treatment of the adult dentition
 D8050 – Interceptive orthodontic treatment of the primary dentition
 D8060 – Interceptive orthodontic treatment of the transitional dentition
 D8070 – Comprehensive orthodontic treatment of the transitional dentition
 D8080 – Comprehensive orthodontic treatment of the adolescent dentition
 D8090 – Comprehensive orthodontic treatment of the adult dentition
 D8220 – Fixed appliance therapy
 D8660 – Pre-orthodontic treatment visit
 D8670 – Periodic orthodontic treatment visit (as part of contract)
 D8680 – Orthodontic retention (removal of appliances, construction and placement of retainer(s))
 D8690 – Orthodontic treatment (alternative billing to a contract fee)
 D8694 – Repair of fixed retainer, includes reattachment

175

NON-COVERED PROCEDURES

Benefits are not payable for procedures that are not listed in one of the above classes of procedures. Following are some of the procedures for which no benefits are payable:

Proc. No.	Description Of Service
D0310	Saliography
D0320	Temporomandibular joint (TMJ) arthrogram, including injection
D0321	X-rays, other temporomandibular joint (TMJ) films, by report
D0322	X-rays, tomographic survey
D0340	X-rays, cephalometric film
D0412	Blood glucose level test – in-office using a glucose meter
D0415	Sterilization or infection control, or bacteriologic studies for determination of pathologic agents
D0425	Caries susceptibility test
D0501	Histopathologic examination
D0502	Other oral pathology procedures, by report
D1204 – D1205	Topical application of fluoride for individuals age 19 and over
D1310	Nutritional counseling for the control or prevention of dental disease
D1320	Tobacco counseling for the control or prevention of oral disease
D1330	Oral hygiene instruction
D2960 – D2962	Labial veneers
D2970	Temporary crown (for fractured tooth)
D3910	Surgical procedure for isolation of tooth with rubber dam
D3950	Canal preparation and fitting of preformed dowel or post
D3960	Bleaching of discolored tooth
D4920	Unscheduled dressing change by someone other than treating dentist
D5810 – D5821	Interim dentures
D5850 – D5851	Tissue conditioning
D5862	Precision attachment, by report
D5911 – D5999	Various prostheses and related procedures
D6010 – D6199	Various implants and related procedures
D6920	Connector bar
D6950	Precision attachment
D7470	Removal of exostosis, maxilla or mandible
D7480	Partial ostectomy (guttering or saucerization)
D7490	Radical resection of mandible with bone graft
D7530	Removal of foreign body, skin, or subcutaneous tissue
D7540	Removal of reaction-producing foreign bodies from musculoskeletal system
D7550	Sequestrectomy for osteomyelitis
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610 – D7780	Various procedures for reduction of fractures
D7810 – D7899	Various procedures related to the temporomandibular joint
D7910 – D7912	Suture of wounds
D7920	Skin grafts
D7940 – D7949	Various osteoplastic, osteotomic, and grafting procedures for repair of defects
D7955	Repair of maxillofacial soft and hard tissue defect
D7980 – D7983	Various procedures related to the salivary gland
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft, mandible or facial bones, by report
D7996	Mandible implant for augmentation purposes (excluding alveolar ridge), by report
D8010 – D8020	Limited orthodontic treatment of the primary or transitional dentition
D8050 – D8070	Interceptive orthodontic treatment of the primary or transitional dentition
D8210 – D8220	Appliance therapy to control harmful habits
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers)
D9130	Temporomandibular joint dysfunction non-invasive physical therapies
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9211	Regional block anesthesia

D9212	Trigeminal block anesthesia
D9215	Local anesthesia
D9221	General anesthesia, each additional 15 minutes
D9230	Analgesia
D9410	House call
D9420	Hospital call
D9430	Office visit for observation during regularly scheduled office hours with no other services performed
D9440	Office visit after regularly scheduled office hours
D9610	Therapeutic drug injection, by report
D9613	Infiltration of sustained release therapeutic drug
D9630	Other drugs and/or medicaments, by report
D9910	Application of desensitizing medicament
D9920	Behavior management, by report
D9930	Treatment of postsurgical complications, unusual circumstances, by report
D9941	Fabrication of athletic mouthguard
D9944	Occlusal guard – hard appliance, full arch
D9945	Occlusal guard – soft appliance, full arch
D9946	Occlusal guard – hard appliance, partial arch
D9950	Occlusion analysis, mounted case
D9951 – D9952	Occlusal adjustment
D9961	Duplicate/copy patient's records
D9970	Enamel microabrasion
D9990	Certified translation or sign-language services – per visit] ¹⁷⁶

SECTION 7 - LIMITATIONS AND EXCLUSIONS

FREQUENCY and AGE LIMITATIONS – PREVENTIVE SERVICES

1. Oral evaluation is limited to [1-4]¹⁷⁷ in any [1-12]¹⁷⁸ month period.
2. Prophylaxis is limited to [1-4]¹⁷⁹ in any [1-12]¹⁸⁰ month period.
3. Fluoride application is limited to [1-4]¹⁸¹ in any [1-12]¹⁸² month period.
4. Bitewing x-rays is limited to [1-2]¹⁸³ in any [6-12]¹⁸⁴ month period.
5. Panoramic/Full-Mouth x-rays –Only one of two procedures [D0210 and D0330]¹⁸⁵ will be allowed once in any [1-5]¹⁸⁶ year period.
6. Sealants per tooth, only for children at least six, but less than 16 years of age once in any [1-36]¹⁸⁷ month period, only for permanent molars.

EXCLUSIONS

Covered Expenses will not include and no benefits will be payable for the following:

1. Expenses in any Class of services that are incurred during the Insured's waiting period for services in that Class (as shown in the Schedule of Benefits), except as may be provided under the Takeover Provisions provision. An Insured is not eligible for Takeover Provisions if Takeover Provisions are not provided, or if Takeover Provisions are provided but the person:
 - a) is a Late Entrant;
 - b) became insured under the Policy after the Employer's Effective Date; or
 - c) was not insured under the Employer's prior plan that was replaced by coverage under the Policy.
2. Any treatment which is for cosmetic purposes, or to correct congenital malformations, other than Medically Necessary treatment of congenital cleft in the lip or palate, or both.
3. Initial placement of any full or partial denture, implants, fixed bridge, or other prosthetic appliance during any period of continuous coverage for the Insured under the Policy, unless such placement is needed because of the extraction of one or more of the Insured's natural teeth during the same period of continuous coverage. Any portion of the expense that is identifiable as applying specifically to the replacement of a tooth extracted before that period of continuous coverage is not a Covered Expense. The extraction of a third molar (wisdom tooth) does not qualify the appliance for payment. Any such appliance must include the replacement of the extracted tooth or teeth.

4. Replacement of any full or partial denture, fixed bridge, other appliance, crown, inlay, onlay, or other precious or semiprecious metal restoration within [1-10]¹⁸⁸ year(s) of the date of the last placement of the item. But if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under the Policy, it will be a Covered Expense. In any event, replacement is not a Covered Expense if the item can instead be repaired or otherwise restored to adequate function.
5. Replacement of an existing implant and/or supported prosthetic device is covered only once every [1-10]¹⁸⁹ year(s) from the placement date of such device and only then if it is unserviceable and cannot be made serviceable. But if a replacement is required because of an accidental bodily injury sustained while the Insured is covered under the Policy, it will be a Covered Expense. In any event, replacement is not a Covered Expense if the item can instead be repaired or otherwise restored to adequate function.
6. Addition of a new tooth or teeth to an existing full or partial denture, fixed bridge, or other prosthetic appliance during any period of continuous coverage for the Insured under the Policy, unless such addition is a replacement of a natural tooth or teeth extracted during the same period of continuous coverage. The extraction of a third molar (wisdom tooth) does not qualify the appliance for payment.
7. Any expense incurred before the Insured's insurance under the Policy starts; or any expense incurred during any period of continuous coverage for the Insured under the Policy if the procedure starts before the period of continuous coverage starts.
8. Any procedure that starts, or any expense that is incurred (regardless of when the procedure starts), after the Insured's insurance under the Policy ends. But this exclusion does not apply for any denture, partial denture, fixed bridge, other appliance, crown, inlay, onlay, or other precious or semiprecious metal restoration if both:
 - (a) the procedure starts while the Insured's insurance under the Policy is in effect; and
 - (b) the expense is incurred within 90 days after the Insured's insurance under the Policy ends.
9. Duplication of appliances, or replacement of lost or stolen appliances.
10. Appliances, restorations, or procedures to:
 - (a) alter vertical dimension;
 - (b) restore or maintain occlusion;
 - (c) splint or replace tooth structure lost as a result of abrasion or attrition; or
 - (d) treat jaw fractures or disturbances of the temporomandibular joint.
11. Any procedure that is not shown on the list of Covered Dental Expense Procedures.
12. Education or training in, or supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
13. Charges for broken appointments or the completion of claim forms.

14. Orthodontic therapy.	190
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15. Any services (including, but not limited to, oral surgery) that are preliminary to, or otherwise associated with, orthodontic therapy (including, but not limited to, exposure of impacted or unerupted teeth or extractions).	191
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16. Subgingival curettage or root planning [(procedure numbers D4220 and D4341)]¹⁹² unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.
17. Charges because of an Insured's injury arising out of, or in the course of, work for wage or profit.
18. Charges because of an Insured Individual sickness, injury, or condition for which he or she is eligible for benefits under any workers' compensation act or similar laws.
19. Charges for which the Insured Individual is not liable or which would not have been made had no insurance been in force.
20. Services that:
 - (a) are not recommended by a Dentist;

- (b) are not required for necessary care and treatment; or
 - (c) do not have a reasonably favorable prognosis.
- 21. Charges because of an Insured's sickness, injury, or other condition due to war or any act of war, declared or not, or sustained while on full-time active duty in the armed forces of any country.
 - 22. Benefits payable to an Insured Individual if payment is not legal where the Insured Individual is living when expenses are incurred.
 - 23. Services related to: equilibration; bite registration or bite analysis.
 - 24. Crowns for the purpose of periodontal splinting.
 - 25. Charges for overdentures, precision or semi-precision attachments and associated endodontic treatment, any other customized attachments, or any specialized prosthodontic techniques or characterizations.
 - 26. Charges for: myofunctional therapy, orthognathic surgery, or athletic mouthguards.
 - 27. Procedures for which benefits are payable under the Employer's medical expense benefit plan for Employees and their Dependents. See the Coordination of Benefits provision for an explanation.
 - 28. Services rendered by the Insured's Spouse, parent, parent-in-law, brother or sister, brother-in-law or sister-in-law, child (of the Insured or the Insured's Spouse), or any person residing in the Insured's household.

SECTION 8 - GENERAL PROVISIONS

Entire Contract

The contract between the parties consists of:

- 1) the Policy;
- 2) the application of the Policyholder, which is made a part of the Policy when issued;
- 3) this Certificate;
- 4) any endorsements, amendments, or riders; and
- 5) the enrollment forms, if any, of each Insured.

All statements made by the Policyholder and Insured shall be deemed representations and not warranties and no statement made by an Insured shall void the insurance or be used in defense to a claim hereunder unless a copy of the instrument containing such statement is or has been furnished to such Insured.

Clerical Error

Clerical errors or delays in keeping records for the Policy:

- 1) will not deny insurance which would otherwise have been granted;
- 2) will not continue insurance which otherwise would have ceased; and
- 3) may call for an adjustment of premium benefits to correct the error.

Certificates

The Company will supply individual Certificates for each Insured. This Certificate will describe:

- 1) the insurance benefits;
- 2) to whom benefits will be paid;
- 3) any limitations of the Policy; and
- 4) all other essential features of the Policy.

If more than one Certificate is issued under the Policy to an Insured, only the last one issued will be in effect. If requested, the Certificates will be provided electronically at no additional cost.

Misstatement of Age

If the date of birth or age of any Insured Individual has been misstated, an adjustment of premium will be of an amount that the premium paid would have purchased at the correct date of birth or age.

Legal Action

No legal action can be brought against Us until at least 60 days after the Insured sends Us the required proof of loss. No such action may be brought against Us after three years after proof of loss is required.

Conformity with State Laws

If any provision of the Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law. If any change to state or federal law affects the Company's liability under the Policy, the Company may change the Policy, the premiums or both. Such change:

- 1) will be effective as of the date of change to the state or federal law; and
- 2) will not be made until the Company gives the Policyholder 31 days' notice.

Incontestability

The validity of the Policy cannot be contested after two years from its date of issue, except for nonpayment of premiums. After coverage for an Insured Individual has been in force for three years, the Company cannot: (a) void the coverage; or (b) deny a claim for loss that starts after the three-year period, because of statements in the application unless they were fraudulent misstatements.

Nothing herein should be construed to prevent the Company from denying any claim on the basis that an individual was not eligible for coverage.

Not in Lieu of Workers' Compensation

The Policy is not in lieu of and does not affect any requirement for coverage by workers' compensation.

Physical Examination

We, at Our own expense, may have the Insured Individual examined when and as often as it may reasonably require during the pendency of a claim hereunder where it is not prohibited by law.

Coordination of Benefits

This coordination of benefits (COB) provision applies when an Insured Individual has dental care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary Plan. The primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary Plan is the secondary Plan. The secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

The following definitions apply only to this provision of the Policy,

A. A "**Plan**" is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); dental care components of long-term care contracts; dental benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-dental components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **“This Plan”** means, in a COB provision, the part of the contract providing the dental care benefits to which the COB provision applies, and which may be reduced because of the benefits of other Plans. Any other part of the contract providing dental care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as orthodontic benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determines whether This Plan is a “primary Plan” or “secondary Plan” when compared to another Plan covering the Insured Individual.

When This Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan’s benefits. When This Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the primary Plan’s benefits, so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. **“Allowable Expense”** is a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Insured Individual. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Insured Individual is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Individual is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

(1) If an Insured Individual is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(2) If an Insured Individual is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(3) If an Insured Individual is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan’s payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable Expense used by the secondary Plan to determine its benefits.

(4) The amount of any benefit reduction by the primary Plan because a person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second opinions and preferred provider arrangements.

(5) If the primary Plan is a Closed Panel Plan with no out-of-network benefits and the secondary plan is not a Closed Panel Plan, the secondary Plan shall pay or provide benefits as if it were primary when no benefits are available from the primary Plan because the Insured Individual uses a non-panel provider, except for emergency services that are paid or provided by the primary.

E. **“Claim Determination Period”** is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person is covered by a Plan during a portion of a Claim Determination Period if that person’s coverage starts or ends during the Claim Determination Period. However, it does not include any part of a year during which a person has no coverage under This Plan, or before the date this COB provision or a similar provision takes effect.

F. **“Closed Panel Plan”** is a Plan that provides health benefits to Insured Individual primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

G. **“Custodial Parent”** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order-of-Benefit Determination Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

A. The primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. (1) Except as provided in paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the plan provided by the contract holder. An example of this type of situation is insurance type coverage that is written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

(1) **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

(2) **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial Parent;
- The Plan covering the spouse of the Custodial Parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary Plan. The Plan covering that same person as a retired or laid-off employee is the secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary Plan and the COBRA or state or other federal continuation coverage is the secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) **Longer or Shorter Length of Coverage.** The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary Plan and the Plan that covered the person the shorter period of time is the secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the primary Plan.

Effect on The Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary Plan will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the primary Plan. The secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

B. If an Insured Individual is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

C. If an Insured Individual is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the Insured Individual. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 9 - CLAIMS PROCEDURES

Notice of Claim

Written notice of claim must be given to Us within 30 days after the incurred date of the services provided for which benefits are payable or as soon as reasonably possible. Notice must be given to the Company, its Administrator, or to one of Our agents. Notice should include the Policyholder's name, Insured Individual's name, and Policy Number. If it will not be reasonably possible to give written notice within the 30-day period stated above, We will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

Claim Forms

When We receive the notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after We have received the notice, the claimant will meet Our proof of loss requirements by giving Us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

Proof of Loss

Written proof of loss must be given to Us within 90 days after the date for which services were provided. If it was not reasonably possible to give written proof within the 90-day period, We will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. In any event, We must receive proof no later than one year from the time specified, except in the absence of legal capacity.

Time of Payment

We will pay all benefits immediately upon receipt of due proof.

Payment of Claims

All benefits will be paid to the Insured, unless an assignment of benefits has been requested by the Insured or We have the obligation to pay the facility or Provider directly. If the Insured dies before all payments due have been made, all remaining amounts payable will be paid to the Insured's estate. Any payment made by Us in good faith pursuant to this provision will fully release Us from liability to the extent of such payment.

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- ¹ The Company's current address and mailing address are bracketed in the event that this information is changed in the future.
- ² The Company's current phone number is bracketed in the event that this information is changed in the future.
- ³ The variable area will reflect the Policy Number.
- ⁴ The variable area will reflect the Certificate Effective Date.
- ⁵ The variable area will reflect the Certificateholder Name.
- ⁶ This section may be omitted in its entirety.
- ⁷ The variable area will reflect the name of the Policyholder.
- ⁸ The variable area will reflect the name of the Policy Anniversary Date.
- ⁹ The variable area will always be included, they are bracketed in the event the officer and title change.
- ¹⁰ This information will be revised for personalization of the Policy as issued.
- ¹¹ The phone number is bracketed in the event that this information is changed in the future.
- ¹² The website is bracketed in the event that this information is changed in the future.
- ¹³ The variable area will reflect the eligible class.
- ¹⁴ The variable area will reflect the Insured description.
- ¹⁵ This information will be revised for personalization of the policy upon issue.
- ¹⁶ This information will be revised for personalization of the policy upon issue.
- ¹⁷ The range will be [0-365].
- ¹⁸ The options are [Yes] [No].
- ¹⁹ The range will be [\$300-\$500].
- ²⁰ This section may be omitted in its entirety.
- ²¹ These options are [Contract][Calendar].
- ²² This information will either appear or not.
- ²³ The ranges are [\$500-99,999].
- ²⁴ The ranges are [\$500-99,999].
- ²⁵ This section may be omitted in its entirety.
- ²⁶ This information will be revised for personalization of the policy upon issue.
- ²⁷ This section may be omitted in its entirety.
- ²⁸ The ranges are [\$0-1,000].
- ²⁹ The ranges are [\$0-1,000].
- ³⁰ The ranges are [0-4].
- ³¹ The ranges are [0- 4].
- ³² This section may be omitted in its entirety.
- ³³ The options are [Yes] [No].
- ³⁴ The options are [Yes] [No].
- ³⁵ The ranges are [0-24 months].
- ³⁶ The ranges are [0-24 months].
- ³⁷ The ranges are [0-24 months].
- ³⁸ The ranges are [0-24 months].
- ³⁹ The ranges are [0-24 months].
- ⁴⁰ The ranges are [0-24 months].
- ⁴¹ This section may be omitted in its entirety.
- ⁴² The ranges are [0-24 months].
- ⁴³ The ranges are [0-24 months].
- ⁴⁴ This section may be omitted in its entirety.
- ⁴⁵ The options are [Yes] [No].
- ⁴⁶ This information will revised for personalization of the policy upon issue.
- ⁴⁷ This provision will either be not-applicable or the ranges [\$0-1,000].
- ⁴⁸ This provision will either be not-applicable or the ranges [\$0-1,000].
- ⁴⁹ This information will be revised for personalization of the policy upon issue.
- ⁵⁰ This provision will either be not-applicable or the ranges [\$0-99,999].
- ⁵¹ This provision will either be not-applicable or the ranges [\$0-99,999].
- ⁵² This provision will either be not-applicable or the ranges [0-24 months].

⁵³ This provision will either be not-applicable or the ranges [0-24 months].
⁵⁴ This provision will either be not-applicable or the ranges [Yes] [No].
⁵⁵ This section may be omitted in its entirety.
⁵⁶ These options are [Contract] [Calendar].
⁵⁷ This section may be omitted in its entirety.
⁵⁸ This section may be omitted in its entirety.
⁵⁹ This section may be omitted in its entirety.
⁶⁰ This section may be omitted in its entirety.
⁶¹ The ranges are [50-100%].
⁶² The ranges are [50-100%].
⁶³ The ranges are [50-100%].
⁶⁴ The ranges are [50-100%].
⁶⁵ The ranges are [50-100%].
⁶⁶ The ranges are [50-100%].
⁶⁷ The ranges are [0-100%].
⁶⁸ The ranges are [0-100%].
⁶⁹ The ranges are [0-100%].
⁷⁰ The ranges are [0-100%].
⁷¹ The ranges are [0-100%].
⁷² The ranges are [0-100%].
⁷³ The ranges are [0-100%].
⁷⁴ The ranges are [0-100%].
⁷⁵ The ranges are [0-100%].
⁷⁶ The ranges are [0-100%].
⁷⁷ The ranges are [0-100%].
⁷⁸ The ranges are [0-100%].
⁷⁹ The ranges are [0-100%].
⁸⁰ The ranges are [0-100%].
⁸¹ The ranges are [0-100%].
⁸² The ranges are [0-100%].
⁸³ The ranges are [0-100%].
⁸⁴ The ranges are [0-100%].
⁸⁵ This section may be omitted in its entirety.
⁸⁶ This section may be omitted in its entirety.
⁸⁷ This information will be revised for personalization of the policy upon issue.
⁸⁸ This information will be revised for personalization of the policy upon issue.
⁸⁹ This section may be omitted in its entirety.
⁹⁰ This information will be revised for personalization of the policy upon issue.
⁹¹ This information will be revised for personalization of the policy upon issue.
⁹² This information will be revised for personalization of the policy upon issue.
⁹³ This information will be revised for personalization of the policy upon issue.
⁹⁴ This section may be omitted in its entirety.
⁹⁵ This section may be omitted in its entirety.
⁹⁶ This information will be revised for personalization of the policy upon issue.
⁹⁷ This section may be omitted in its entirety.
⁹⁸ This information will be revised for personalization of the policy upon issue.
⁹⁹ This section may be omitted in its entirety.
¹⁰⁰ This information will be revised for personalization of the policy upon issue.
¹⁰¹ This information will be revised for personalization of the policy upon issue.
¹⁰² This section may be omitted in its entirety.
¹⁰³ These options are [Contract] [Calendar].
¹⁰⁴ This range will be [\$200-500.00].
¹⁰⁵ These options are [Contract] [Calendar].
¹⁰⁶ These options are [Contract] [Calendar].

¹⁰⁷ This range will be [2-5].
¹⁰⁸ This section may be omitted in its entirety.
¹⁰⁹ This section may be omitted in its entirety.
¹¹⁰ This section may be omitted in its entirety.
¹¹¹ This section may be omitted in its entirety.
¹¹² This section may be omitted in its entirety.
¹¹³ This section may be omitted in its entirety.
¹¹⁴ This section may be omitted in its entirety.
¹¹⁵ This section may be omitted in its entirety.
¹¹⁶ This section may be omitted in its entirety.
¹¹⁷ The Company's current address and mailing address are bracketed in the event that this information is changed in the future.
¹¹⁸ This section may be omitted in its entirety.
¹¹⁹ These options are [Contract] [Calendar].
¹²⁰ This section is bracketed in case Dependent age mandates change.
¹²¹ This section is bracketed in case Dependent age mandates change.
¹²² This section may be omitted in its entirety.
¹²³ These options are [Contract] [Calendar].
¹²⁴ This section may be omitted in its entirety.
¹²⁵ This section may be omitted in its entirety.
¹²⁶ This information will be revised for personalization of the policy upon issue.
¹²⁷ This section may be omitted in its entirety.
¹²⁸ This section may be omitted in its entirety.
¹²⁹ These options are [Contract][Calendar].
¹³⁰ These options are [Contract][Calendar].
¹³¹ This section may be omitted in its entirety.
¹³² This section may be omitted in its entirety.
¹³³ This section may be omitted in its entirety.
¹³⁴ This section may be omitted in its entirety.
¹³⁵ This section may be omitted in its entirety.
¹³⁶ This information will be revised for personalization of the policy upon issue.
¹³⁷ This range is [5-1,560 hours].
¹³⁸ These options are [per week] [per year].
¹³⁹ This section may be omitted in its entirety.
¹⁴⁰ This section may be omitted in its entirety.
¹⁴¹ This section may be omitted in its entirety.
¹⁴² This section may be omitted in its entirety.
¹⁴³ This section may be omitted in its entirety.
¹⁴⁴ This section is bracketed in case Dependent age mandates change.
¹⁴⁵ This section is bracketed in case Dependent age mandates change.
¹⁴⁶ These options are [Employees] [Retirees].
¹⁴⁷ These options are [Employees] [Retirees].
¹⁴⁸ These options are [Employees] [Retirees].
¹⁴⁹ These options are [Employees] [Retirees].
¹⁵⁰ This section may be omitted in its entirety.
¹⁵¹ This section may be omitted in its entirety.
¹⁵² This section may be omitted in its entirety.
¹⁵³ This section may be omitted in its entirety.
¹⁵⁴ This range is [1-24 months].
¹⁵⁵ This section may be omitted in its entirety.
¹⁵⁶ This range is [Jan. 1-Dec. 31].
¹⁵⁷ This range is [1- 31].
¹⁵⁸ This section may be omitted in its entirety.
¹⁵⁹ This section may be omitted in its entirety.

-
- ¹⁶⁰ These options are [1st] [15th].
- ¹⁶¹ This section may be omitted in its entirety.
- ¹⁶² This section may be omitted in its entirety.
- ¹⁶³ This range is [30-90 days].
- ¹⁶⁴ This range is [30-90 days].
- ¹⁶⁵ This range is [60-365 days].
- ¹⁶⁶ This range is [2-3 years].
- ¹⁶⁷ This range is [50-65].
- ¹⁶⁸ These options are [Contract] [Calendar].
- ¹⁶⁹ These options are [Contract] [Calendar].
- ¹⁷⁰ This section may be omitted in its entirety.
- ¹⁷¹ This section may be omitted in its entirety.
- ¹⁷² This section may be omitted in its entirety.
- ¹⁷³ This section may be omitted in its entirety.
- ¹⁷⁴ There will always be a Class I, Class II and Class III. Each procedure will be placed in one of the three classes based on the Policyholder's selection. The numeric codes may be updated as required by the American Dental Association or similar authority.
- ¹⁷⁵ The Class IV section may be deleted in its entirety based on the Policyholder's selection. These procedure codes will not be placed into Class I, II or III. These numeric codes may be updated as required by the American Dental Association or similar authority.
- ¹⁷⁶ These codes may be updated as required by the American Dental Association or similar authority.
- ¹⁷⁷ This range is [1-4].
- ¹⁷⁸ This range is [1-12 months].
- ¹⁷⁹ This range is [1-4].
- ¹⁸⁰ This range is [1-12 months].
- ¹⁸¹ This range is [1-4].
- ¹⁸² This range is [1-12 months].
- ¹⁸³ This range is [1-2].
- ¹⁸⁴ This range is [6-12 months].
- ¹⁸⁵ This section may be omitted in its entirety.
- ¹⁸⁶ This range is [1-5].
- ¹⁸⁷ This range is [1-36].
- ¹⁸⁸ This range is [1-10 years].
- ¹⁸⁹ This range is [1-10 years].
- ¹⁹⁰ This section may be omitted in its entirety.
- ¹⁹¹ This section may be omitted in its entirety.
- ¹⁹² This section may be omitted in its entirety.

GROUP DENTAL POLICY APPLICATION



Underwritten by: Companion Life Insurance Company

Administered by: [ABC Administrator]

123 Any Street

Any City, Any State 00000

Telephone Number: 123-456-7890

Fax: 123-456-0789]¹

Please Print or Type					
APPLICATION INFORMATION					
1. Full Legal Name of Applicant (As it should appear in policy)				Telephone Number ()	
2. Applicant's Federal Tax ID Number					
3. Address		Street	P.O. Box	City	State ZIP
4. Administrative Correspondence with the Applicant should be addressed to:					
Name		Title		Email Address	
5. Nature of Business			6. Requested Effective Date: / /		
7. Are there subsidiary businesses covered under this plan?			If YES, please state name and nature of each subsidiary or affiliate.		
Are separate billings required?			If YES, please provide billing instructions.		
8. Type of Administration: <input type="checkbox"/> Home Office Administered <input type="checkbox"/> Self-Administered <input type="checkbox"/> Third Party Administered					
TPA Name					
ELIGIBILITY					
An Eligible Active Employee works [5-1,560]² hours or more [per week][per year]³ and is a legal resident or citizen of the U.S.[]; and] [; or] [is a Retiree of the Employer[.]] [;or] [is a Non-Permanent Employee.]⁴					
9. Current eligible enrollees are to be covered: <input type="checkbox"/> Immediately on the Requested Effective Date. <input type="checkbox"/> After _____ days of continuous employment. <input type="checkbox"/> First of the month following _ days of continuous employment.			10. Employees hired after the plan effective dates are to be covered: <input type="checkbox"/> Immediately. <input type="checkbox"/> After _____ days of continuous employment. <input type="checkbox"/> First of the month following _____ days of continuous employment.		
11. Percent of Premium Paid by Applicant: <input type="checkbox"/> Enrollee Only _____ % <input type="checkbox"/> Family Enrollee & Dependents _____ %					
Additional notes:					
12. Number of eligible employees:			Number of enrolled employees:		
[SEE ATTACHED PROPOSAL FOR SPECIFICATIONS FOR INSURANCE] [SPECIFICATIONS FOR INSURANCE]⁵					
[13. Will this coverage replace any existing dental insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No] ⁶				If YES, name existing insurance carrier:	
[14. Existing Plan Effective Date: / /] ⁷		[15. Termination Date of Existing Plan / /] ⁸		[16. Check coverages being replaced: <input type="checkbox"/> Preventive <input type="checkbox"/> Basic <input type="checkbox"/> Major <input type="checkbox"/> Orthodontia] ⁹	
[17. Is prior insurance credit (takeover benefits) requested? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type is requested? <input type="checkbox"/> Standard <input type="checkbox"/> Preferred <input type="checkbox"/> Enhanced] ¹⁰					
[18. The following documentation is required when prior insurance credit is requested. Your current dental plan must have been in effect continuously for at least 12 months prior to Effective Date. • Evidence that the prior carrier's coverage has been in force for at least 12 months. • A copy of the most recent bill which includes a listing of all covered enrollees and their Effective Dates of coverage (Standard Takeover only).] ¹¹					

FRAUD NOTICE

[General Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. The fraud warnings listed below are applicable in the states of AL, AK, AZ, AR, CO, DE, DC, FL, ID, IN, KS, KY, LA, ME, MD, MA, MN, NH, NM, OH, OK, OR, PA, RI, TN, TX, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false

information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application or contract for insurance may be found guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: ANY PERSON WHO, WITH A PURPOSE TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS SUBJECT TO PROSECUTION AND PUNISHMENT FOR INSURANCE FRAUD, AS PROVIDED IN R.S.A. 638:20.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of fraud and may be subject to criminal or civil penalties.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]¹²

Quotations were based on the proposal data submitted to Companion Life. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

Dated at _____ this _____ day of _____, 20_____
City/State

Signature of Employer

Title

Witness

AGENT'S REPORT

[19. Requested Initial Deposit (Minimum first month's premium requested.)
\$]¹³

20. Agent/Broker Name (Please Print) Telephone Number
() -

21. Address

City County State ZIP

22. Agent/Broker Email Address:

23. Is Agent or Broker licensed and appointed by Companion for the types of insurance solicited where this group is located?

☐ Yes ☐ No

Company Issued Agent Code Number _____

Agent State License Number _____ State _____

24. Signature of Agent/Broker _____ Date ____/____/____



www.CompanionLife.com

PRODUCTS NOT APPROVED IN ALL STATES

¹ The Administrator's current address, mailing address, and phone number are bracketed in the event that this information is changed in the future.

² This range is [5-1,560] hours.

³ The options are [per week][per year].

⁴ This information will be revised for personalization of the Policy upon issue.

⁵ This information will be revised for personalization of the Policy upon issue.

⁶ This section may be omitted in its entirety.

⁷ This section may be omitted in its entirety.

⁸ This section may be omitted in its entirety.

⁹ This section may be omitted in its entirety.

¹⁰ This section may be omitted in its entirety.

¹¹ This section may be omitted in its entirety.

¹² The Fraud Notice may be revised for state statutory or regulatory changes or to include only the state applicable to state-specific forms.

¹³ This section may be omitted in its entirety.

GROUP DENTAL EMPLOYEE ENROLLMENT APPLICATION AND CHANGE REQUEST FORM

COMPANION LIFE INSURANCE COMPANY

Administered by:

[ABC Administrator
Any Street, Any City, Any State 00000
Telephone Number: 123-456-7890
Fax: 123-456-0789]¹

Underwritten by:



EMPLOYER INFORMATION – to be completed by the Policyholder or Group Administrator

Employer Name: _____ Requested Effective Date: / /
Group Number: _____ Dept/Div Number: _____ Hours Worked per Week: _____ Hire Date: / /

APPLICANT INFORMATION (PLEASE PRINT) – to be completed by the Employee/Enrollee

Last Name (Include Jr., Sr., etc.)		First Name		M.I.	
Street Address		Apt Number	City	State/Zip	
Social Security Number		Home Telephone		Work Telephone	
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth(MM-DD-YY) / /			

PLAN AND COVERAGE SELECTION

☐ Employee ☐ Employee + Spouse² ☐ Employee + children³ ☐ Family⁴

DEPENDENT INFORMATION (please attach additional pages as needed)

Do any of your Dependents have any other dental

Spouse Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM-DD-YY) / /	<input type="checkbox"/> Yes Name of Carrier <input type="checkbox"/> No
Child Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM-DD-YY) / /	<input type="checkbox"/> Yes Name of Carrier <input type="checkbox"/> No
Child Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM-DD-YY) / /	<input type="checkbox"/> Yes Name of Carrier <input type="checkbox"/> No
Child Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM-DD-YY) / /	<input type="checkbox"/> Yes Name of Carrier <input type="checkbox"/> No
Child Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM-DD-YY) / /	<input type="checkbox"/> Yes Name of Carrier <input type="checkbox"/> No

DEPENDENTS: Eligible Dependents are determined by your employer's eligibility terms.

AUTHORIZATION FOR DEDUCTION

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my Employer to deduct the contribution from my wages.

Signature: _____ Date: _____

REFUSAL/WAIVER – Complete ONLY if you are declining coverage for yourself or any Dependent.

I decline coverage for: ☐ Myself ☐ My Spouse ☐ My Children

Signature: _____ Date: _____

FRAUD NOTICE

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The fraud warnings listed below are applicable in the states of AL, AK, AZ, AR, CO, DE, DC, FL, ID, IN, KS, KY, LA, ME, MD, MA, MN, NH, NM, OH, OK, OR, PA, RI, TN, TX, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act punishable under law and may be subject to civil penalties.

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material thereto commits a fraudulent insurance act, which is a crime.

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Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application or contract for insurance may be found guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of fraud and may be subject to criminal or civil penalties.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]⁵

¹ The Administrator's current address, mailing address, and phone number are bracketed in the event that this information is changed in the future.

² This information will be revised for personalization of the plan.

³ This information will be revised for personalization of the plan.

⁴ This information will be revised for personalization of the plan.

⁵ The Fraud Notice may be revised for state statutory or regulatory changes or to include only the state applicable to state-specific forms.

State:	District of Columbia	Filing Company:	Companion Life Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Group Dental		
Project Name/Number:	Group Dental/CL-DEN-1000-P-DC FORM		

Supporting Document Schedules

Satisfied - Item:	Third Party Authorization
Comments:	
Attachment(s):	Authorization Letter.PDF
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Readability Certification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Statement of Variability
Comments:	
Attachment(s):	CL-DEN-1000-SOV-DC.pdf
Item Status:	
Status Date:	



Companion Life

COMPANION LIFE INSURANCE COMPANY
7909 Parklane Road, Suite 200, Columbia, South Carolina 29223-5666
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

NAIC Company Code 77828

January 10, 2019

VIA E-MAIL: jhammerquist@lewisellis.com

Josh Hammerquist, Vice President
Lewis & Ellis, Inc.
700 Central Expressway South, Suite 550
Allen, TX 75013-8098

Re: Authorization Letter

Dear Mr. Hammerquist,

This letter authorizes Lewis & Ellis, Inc. to submit filings via the System for Electronic Rate Filing and Forms ("SERFF") under its account and to perform each and every action necessary in connection with such submission on behalf of Companion Life Insurance Company ("Companion Life"). This authorization includes permitting Lewis & Ellis, Inc. to respond to state inquiries arising out of or related to SERFF filings. This authorization shall remain in place until the engagement with Lewis & Ellis, Inc. ends.

If you have any questions, please do not hesitate to call me at 803.264.5070.

Sincerely,

Diane Fischer
Chief Financial Officer

Readability Certification

Insurance Company: Companion Life Insurance Company

<u>Form Number</u>	<u>Description of Form</u>	<u>Score</u>
CL-DEN-1000-P	Policy	56.9
CL-DEN-1000-C	Certificate	51.2
CL-DEN-1000-APP	Application	50.4
CL-DEN-1000-ENR	Enrollment Form	51.1

I hereby certify that the above referenced forms comply with the readability requirements of this State.



Authorized Signature



Name



Title



Date

DESCRIPTION OF VARIABLES

GENERAL

1. All benefit amounts reflect the applicable ranges in options with the minimum and maximum amount shown.
2. All time periods reflect the applicable ranges in options with the minimum and maximum period shown.
3. When numbered and/or lettered items in a list are bracketed, such as [(d)... [(1)..., all remaining items in the list may be renumbered and/or re-lettered if parts of the list are deleted.
4. The variable areas in the Schedule of Benefits such as [N/A, Yes/No] or [Yes/No] will be completed with case specific information as the Policy issued.
5. The variables areas of [Employee], [Employee/Retiree], [Employees/Retirees] or [Employee Dependent/Retirees] will be revised for personalization of the Policy as issued.
6. The variable area of [ABC Marketer] will be revised for personalization of the Policy as issued.
7. No variable item that is subject to change will be completed with a fill-in that violates any applicable state law.

STATEMENT OF VARIABILITY: CL-DEN-1000-P-DC

End note	Section	Provision	Description of Variables
1.	Above Section	Address, Mailing Address, Phone Number	The Company's current address and mailing address are bracketed in the event that this information is changed in the future.
2.	Above Section	Address, Mailing Address, Phone Number	The Company's current phone number is bracketed in the event that this information is changed in the future.
3.	Above Section	Name of Policyholder	The variable area [ABC Corporation] will reflect the name of the Policyholder.
4.	Title Page	Policy Number	The variable area will reflect the Policy Number.
5.	Title Page	Effective Date	The variable area will reflect the Policy Effective Date.
6.	Title Page	Policy Anniversary Date	The variable area will reflect the Policy Anniversary Date.
7.	Title Page	Officer Signature	The variable area will always be included; they are bracketed in the event the officer and title change.
8.	Title Page	Service or Questions	This information will be revised for personalization of the Policy as issued.
9.	Title Page	Service or Questions	The phone number is bracketed in the event that this information is changed in the future.
10.	Title Page	Service or Questions	The website is bracketed in the event that this information is changed in the future.

11.	1 – Schedule of Benefits	Schedule of Benefits	This variable may be excluded in its entirety if the group does not select orthodontic benefits.
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STATEMENT OF VARIABILITY: CL-DEN-1000-C-DC

End note	Section	Provision	Description of Variables
1.	Title Page	Address	The Company's current address and mailing address are bracketed in the event that this information is changed in the future.
2.	Title Page	Telephone Number	The Company's current phone number is bracketed in the event that this information is changed in the future.
3.	Title Page	Policy Number	The variable area will reflect the Policy Number.
4.	Title Page	Certificate Effective Date	The variable area will reflect the Certificate Effective Date.
5.	Title Page	Certificateholder	The variable area will reflect the Certificateholder.
6.	Title Page	Certificateholder	This section may be omitted in its entirety.
7.	Title Page	Policyholder	The variable area [ABC Corporation] will reflect the name of the Policyholder.
8.	Title Page	Policy Anniversary Date	The variable area will reflect the Policy Anniversary Date.
9.	Title Page	Officer Signature	The variable area will always be included; they are bracketed in the event the officer and title change.
10.	Title Page	Service or Questions	This information will be revised for personalization of the Policy as issued.
11.	Title Page	Service or Questions	The phone number is bracketed in the event that this information is changed in the future.
12.	Title Page	Service or Questions	The website is bracketed in the event that this information is changed in the future.
13.	Schedule of Benefits	Classes Eligible for Insurance	The variable area will reflect the eligible class.
14.	Schedule of Benefits	Persons Covered	The variable area will reflect the persons covered description.
15.	Schedule of Benefits	Contributions	This information will be revised for personalization of the Policy upon issue.
16.	Schedule of Benefits	Contributions	This information will be revised for personalization of the Policy upon issue.
17.	Schedule of Benefits	Eligibility Waiting Period	The range will be [0-365].
18.	Schedule of Benefits	Prior Insurance Credit	The options are [Yes] [No].

19.	Schedule of Benefits	Predetermination of Benefits Amount	The range will be [\$300-\$500].
20.	Schedule of Benefits	Maximum Year Benefit	This section may be omitted in its entirety.
21.	Schedule of Benefits	Maximum Year Benefit	These options are [Contract][Calendar].
22.	Schedule of Benefits	Maximum Year Benefit	This information will either appear or not.
23.	Schedule of Benefits	Maximum Year Benefit	The ranges are [\$500-99,999].
24.	Schedule of Benefits	Maximum Year Benefit	The ranges are [\$500-99,999].
25.	Schedule of Benefits	Deductible Amount	This section may be omitted in its entirety.
26.	Schedule of Benefits	Deductible Amount	This information will be revised for personalization of the Policy upon issue.
27.	Schedule of Benefits	Deductible Amount	This section may be omitted in its entirety.
28.	Schedule of Benefits	Deductible Amount	The ranges are [\$0-1,000].
29.	Schedule of Benefits	Deductible Amount	The ranges are [\$0-1,000].
30.	Schedule of Benefits	Family Deductible	The ranges are [0-4].
31.	Schedule of Benefits	Family Deductible	The ranges are [0-4].
32.	Schedule of Benefits	Family Deductible	This section may be omitted in its entirety.
33.	Schedule of Benefits	Deductible Waived for Class I	The options are [Yes] [No].
34.	Schedule of Benefits	Deductible Waived for Class I	The options are [Yes] [No].
35.	Schedule of Benefits	Benefit Waiting Period for Class II	The ranges are [0-24 months].
36.	Schedule of Benefits	Benefit Waiting Period for Class II	The ranges are [0-24 months].
37.	Schedule of Benefits	Benefit Waiting Period for Class III	The ranges are [0-24 months].
38.	Schedule of Benefits	Benefit Waiting Period for Class III	The ranges are [0-24 months].
39.	Schedule of Benefits	Benefit Waiting Period for Class II for Late Entrants	The ranges are [0-24 months].
40.	Schedule of Benefits	Benefit Waiting Period for Class II for Late	The ranges are [0-24 months].

		Entrants	
41.	Schedule of Benefits	Benefit Waiting Period for Class II for Late Entrants	This section may be omitted in its entirety.
42.	Schedule of Benefits	Benefit Waiting Period for Class III for Late Entrants	The ranges are [0-24 months].
43.	Schedule of Benefits	Benefit Waiting Period for Class III for Late Entrants	The ranges are [0-24 months].
44.	Schedule of Benefits	Benefit Waiting Period for Class III for Late Entrants	This section may be omitted in its entirety.
45.	Schedule of Benefits	Orthodontic Services	The options are [Yes] [No].
46.	Schedule of Benefits	Orthodontic Services	This information will be revised for personalization of the Policy upon issue.
47.	Schedule of Benefits	Orthodontic Services	This provision will either be not-applicable or the ranges [\$0-1,000].
48.	Schedule of Benefits	Orthodontic Services	This provision will either be not-applicable or the ranges [\$0-1,000].
49.	Schedule of Benefits	Orthodontic Services	This information will be revised for personalization of the Policy upon issue.
50.	Schedule of Benefits	Orthodontic Services	This provision will either be not-applicable or the ranges [\$0-99,999].
51.	Schedule of Benefits	Orthodontic Services	This provision will either be not-applicable or the ranges [\$0-99,999].
52.	Schedule of Benefits	Orthodontic Services	This provision will either be not-applicable or the ranges [0-24 months].
53.	Schedule of Benefits	Orthodontic Services	This provision will either be not-applicable or the ranges [0-24 months].
54.	Schedule of Benefits	Orthodontic Services	This provision will either be not-applicable or the options are [Yes] [No].
55.	Schedule of Benefits	Orthodontic Services	This section may be omitted in its entirety.
56.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable	These options are [Contract] [Calendar].
57.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable	This section may be omitted in its entirety.
58.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – 1 st Year	This section may be omitted in its entirety.

59.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – 2 nd Year	This section may be omitted in its entirety.
60.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – 3 rd Year	This section may be omitted in its entirety.
61.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class I – 1 st Year In-Network	The ranges are [50-100%].
62.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class I – 1 st Year Out-of-Network	The ranges are [50-100%].
63.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class I – 2 nd Year In-Network	The ranges are [50-100%].
64.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class I – 2 nd Year Out-of-Network	The ranges are [50-100%].
65.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class I – 3 rd Year In-Network	The ranges are [50-100%].
66.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class I – 3 rd Year Out-of-Network	The ranges are [50-100%].
67.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class II – 1 st Year In-Network	The ranges are [0-100%].
68.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class II – 1 st Year Out-of-Network	The ranges are [0-100%].
69.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class II – 2 nd Year In-Network	The ranges are [0-100%].
70.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class II – 2 nd Year Out-of-Network	The ranges are [0-100%].

71.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class I – 3 rd Year In-Network	The ranges are [0-100%].
72.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class II – 3 rd Year Out-of-Network	The ranges are [0-100%].
73.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class III – 1 st Year In-Network	The ranges are [0-100%].
74.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class III – 1 st Year Out-of-Network	The ranges are [0-100%].
75.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class III – 2 nd Year In-Network	The ranges are [0-100%].
76.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class III – 2 nd Year Out-of-Network	The ranges are [0-100%].
77.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class III – 3 rd Year In-Network	The ranges are [0-100%].
78.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class III – 3 rd Year Out-of-Network	The ranges are [0-100%].
79.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class IV – 1 st Year In-Network	The ranges are [0-100%].
80.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class IV – 1 st Year Out-of-Network	The ranges are [0-100%].
81.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class IV – 2 nd Year In-Network	The ranges are [0-100%].
82.	Schedule of Benefits	Percentage of Covered Dental Expenses	The ranges are [0-100%].

		Payable – Class IV – 2 nd Year Out-of-Network	
83.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class IV – 3 rd Year In-Network	The ranges are [0-100%].
84.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable – Class IV – 3 rd Year Out-of-Network	The ranges are [0-100%].
85.	Schedule of Benefits	Percentage of Covered Dental Expenses Payable	This section may be omitted in its entirety.
86.	Schedule of Benefits	Takeover Provisions	This section may be omitted in its entirety.
87.	Schedule of Benefits	Standard Takeover	This information will be revised for personalization of the Policy upon issue.
88.	Schedule of Benefits	Standard Takeover	This information will be revised for personalization of the Policy upon issue.
89.	Schedule of Benefits	Standard Takeover	This section may be omitted in its entirety.
90.	Schedule of Benefits	Preferred Takeover	This information will be revised for personalization of the Policy upon issue.
91.	Schedule of Benefits	Preferred Takeover	This information will be revised for personalization of the Policy upon issue.
92.	Schedule of Benefits	Preferred Takeover	This information will be revised for personalization of the Policy upon issue.
93.	Schedule of Benefits	Preferred Takeover	This information will be revised for personalization of the Policy upon issue.
94.	Schedule of Benefits	Preferred Takeover	This section may be omitted in its entirety.
95.	Schedule of Benefits	Preferred Takeover	This section may be omitted in its entirety.
96.	Schedule of Benefits	Enhanced Takeover	This information will be revised for personalization of the Policy upon issue.
97.	Schedule of Benefits	Enhanced Takeover	This section may be omitted in its entirety.
98.	Schedule of Benefits	Enhanced Takeover	This information will be revised for personalization of the Policy upon issue.
99.	Schedule of Benefits	Enhanced Takeover	This section may be omitted in its entirety.

100.	Schedule of Benefits	Incentive Plan Takeover	This information will be revised for personalization of the Policy upon issue.
101.	Schedule of Benefits	Incentive Plan Takeover	This information will be revised for personalization of the Policy upon issue.
102.	Schedule of Benefits	Incentive Plan Takeover	This section may be omitted in its entirety.
103.	Schedule of Benefits	Increasing Maximum Benefit	These options are [Contract][Calendar].
104.	Schedule of Benefits	Increasing Maximum Benefit	This range will be [\$200-500].
105.	Schedule of Benefits	Increasing Maximum Benefit	These options are [Contract][Calendar].
106.	Schedule of Benefits	Increasing Maximum Benefit	These options are [Contract][Calendar].
107.	Schedule of Benefits	Increasing Maximum Benefit	This range will be [2-5].
108.	Schedule of Benefits	Increasing Maximum Benefit	This section may be omitted in its entirety.
109.	Definitions	Active Employee	This section may be omitted in its entirety.
110.	Definitions	Active Service	This section may be omitted in its entirety.
111.	Definitions	Actively at Work	This section may be omitted in its entirety.
112.	Definitions	Allowable Charge	This section may be omitted in its entirety. If used, only 1 definition will appear.
113.	Definitions	Allowable Charge	This section may be omitted in its entirety. If used, only 1 definition will appear.
114.	Definitions	Allowable Charge	This section may be omitted in its entirety. If used, only 1 definition will appear.
115.	Definitions	Benefit Waiting Period	This section may be omitted in its entirety.
116.	Definitions	Calendar Year	This section may be omitted in its entirety.
117.	Definitions	Company	The Company's current mailing address are bracketed in the event that this information is changed in the future.
118.	Definitions	Contract Year	This section may be omitted in its entirety.
119.	Definitions	Deductible	These options are [Contract][Calendar].
120.	Definitions	Dependent	This section is bracketed in case Dependent age mandates change.
121.	Definitions	Dependent	This section is bracketed in case Dependent age mandates change.
122.	Definitions	Employee	This section may be omitted in its entirety.

123.	Definitions	Family Deductible	These options are [Contract][Calendar].
124.	Definitions	Family Deductible	This section may be omitted in its entirety.
125.	Definitions	Family Deductible	This section may be omitted in its entirety.
126.	Definitions	Insured	This information will be revised for personalization of the Policy upon issue.
127.	Definitions	Late Entrant	This section may be omitted in its entirety.
128.	Definitions	Lifetime Deductible	This section may be omitted in its entirety.
129.	Definitions	Maximum Year Benefit	These options are [Contract][Calendar].
130.	Definitions	Maximum Year Benefit	These options are [Contract][Calendar].
131.	Definitions	Non-Permanent Employee	This section may be omitted in its entirety.
132.	Definitions	Non-Participating Employee	This section may be omitted in its entirety.
133.	Definitions	Participating Provider	This section may be omitted in its entirety.
134.	Definitions	Previous Policy	This section may be omitted in its entirety.
135.	Definitions	Retiree	This section may be omitted in its entirety.
136.	Definitions	Spouse	This information will be revised for personalization of the Policy upon issue.
137.	Eligibility	Eligible Employee	This range is [5-1,560 hours].
138.	Eligibility	Eligible Employee	These options are [per week] [per year].
139.	Eligibility	Eligible Employee	This section may be omitted in its entirety.
140.	Eligibility	Eligible Employee	This section may be omitted in its entirety.
141.	Eligibility	Eligible Employee	This section may be omitted in its entirety.
142.	Eligibility	Eligible Employee	This section may be omitted in its entirety.
143.	Eligibility	Eligible Employee	This section may be omitted in its entirety.
144.	Eligibility	Eligible Dependents	This section is bracketed in case Dependent age mandates change.
145.	Eligibility	Eligible Dependents	This section is bracketed in case Dependent age mandates change.

146.	Eligibility	Eligible Dependents	These options are [Employee] [Retiree].
147.	Eligibility	Eligible Dependents	These options are [Employee] [Retiree].
148.	Eligibility	Eligible Dependents	These options are [Employee] [Retiree].
149.	Eligibility	Eligible Dependents	These options are [Employees] [Retirees].
150.	Eligibility	Eligible Dependents	This section may be omitted in its entirety.
151.	Eligibility	Dependents after Coverage is Effective	This section may be omitted in its entirety.
152.	Eligibility	Retiree	This section may be omitted in its entirety.
153.	Eligibility	Non-Permanent Employee	This section may be omitted in its entirety.
154.	Eligibility	Eligibility Waiting Period	This range is [1-24].
155.	Eligibility	Eligibility Waiting Period	This section may be omitted in its entirety.
156.	Eligibility	Enrollment if a Section 125 Plan	This range is [Jan. 1 st -Dec. 31 st].
157.	Eligibility	Eligible Employee Effective Date	This range is [1 st - 31 st].
158.	Eligibility	Eligible Employee Effective Date	This section may be omitted in its entirety.
159.	Eligibility	Eligible Employee Effective Date	This section may be omitted in its entirety.
160.	Eligibility	Benefit Classification Change	These options are [1 st] [15 th].
161.	Eligibility	Benefit Classification Change	This section may be omitted in its entirety.
162.	Termination/ Nonrenewal/ Continuation	Continuation of Coverage	This section may be omitted in its entirety.
163.	Termination/ Nonrenewal/ Continuation	Death or Divorce – For Dependents Only	This range is [30-90].
164.	Termination/ Nonrenewal/ Continuation	Death or Divorce – For Dependents Only	This range is [30-90].
165.	Termination/ Nonrenewal/ Continuation	Death or Divorce – For Dependents Only	This range is [60-365].
166.	Termination/ Nonrenewal/ Continuation	Death or Divorce – For Dependents Only	This range is [2-3].

167.	Termination/ Nonrenewal/ Continuation	Death or Divorce – For Dependents Only	This range is [50-65].
168.	Benefits/Coverage	First paragraph	These options are [Contract][Calendar].
169.	Benefits/Coverage	Family Deductible	These options are [Contract][Calendar].
170.	Benefits/Coverage	Family Deductible	This section may be omitted in its entirety.
171.	Benefits/Coverage	Family Deductible	This section may be omitted in its entirety.
172.	Benefits/Coverage	Lifetime Deductible	This section may be omitted in its entirety.
173.	Benefits/Coverage	Benefit Waiting Period	This section may be omitted in its entirety.
174.	Benefits/Coverage	Covered Procedures	There will always be a Class I, Class II, and Class III. Each procedure will be placed in one of the three classes based on the Policyholder's selection. The numeric codes may be updated as required by the American Dental Association or similar authority.
175.	Benefits/Coverage	Orthodontia Services	The Class IV section may be deleted in its entirety based on the Policyholder's selection. These procedure codes will not be placed into Class I, II, or III. These numeric codes may be updated as required by the American Dental Association or similar authority.
176.	Benefits/Coverage	Non-Covered Procedures	These codes may be updated as required by the American Dental Association or similar authority.
177.	Limitations and Exclusions	Frequency and Age Limitations – Preventive Services	This range is [1-4].
178.	Limitations and Exclusions	Frequency and Age Limitations – Preventive Services	This range is [1-12].
179.	Limitations and Exclusions	Frequency and Age Limitations – Preventive Services	This range is [1-4].
180.	Limitations and Exclusions	Frequency and Age Limitations – Preventive Services	This range is [1-12].
181.	Limitations and Exclusions	Frequency and Age Limitations – Preventive Services	This range is [1-4].
182.	Limitations and Exclusions	Frequency and Age Limitations – Preventive Services	This range is [1-12].
183.	Limitations and Exclusions	Frequency and Age Limitations –	This range is [1-2].

		Preventive Services	
184.	Limitations and Exclusions	Frequency and Age Limitations – Preventive Services	This range is [6-12].
185.	Limitations and Exclusions	Frequency and Age Limitations – Preventive Services	This section may be omitted in its entirety.
186.	Limitations and Exclusions	Frequency and Age Limitations – Preventive Services	This range is [1-5].
187.	Limitations and Exclusions	Frequency and Age Limitations – Preventive Services	This range is [1-36].
188.	Limitations and Exclusions	Exclusions	This range is [1-10].
189.	Limitations and Exclusions	Exclusions	This range is [1-10].
190.	Limitations and Exclusions	Exclusions	This section may be omitted in its entirety.
191.	Limitations and Exclusions	Exclusions	This section may be omitted in its entirety.
192.	Limitations and Exclusions	Exclusions	This section may be omitted in its entirety.

STATEMENT OF VARIABILITY: CL-DEN-1000-ENR

End note	Section	Provision	Description of Variables
1.	Administered By	Contact Information	The Administrator's current address, mailing address, and phone number are bracketed in the event that this information is changed in the future.
2.	Plan and Coverage Selection	Employee + Spouse	This information will be revised for personalization of the plan.
3.	Plan and Coverage Selection	Employee + children	This information will be revised for personalization of the plan.
4.	Plan and Coverage Selection	Family	This information will be revised for personalization of the plan.
5.	Fraud Notice	Fraud Notice	The Fraud Notice may be revised for state statutory or regulatory changes or to include only the state applicable to state-specific forms.

STATEMENT OF VARIABILITY: CL-DEN-1000-APP

End note	Section	Provision	Description of Variables
1.	Administered By	Contact Information	The Administrator current address, mailing address and phone number are bracketed in the event that this information is changed in the future.
2.	Eligibility	Definition – Hours	This range is [5-1,560] hours.
3.	Eligibility	Definition – Time Period	The options are [per week][per year].
4.	Eligibility	Description	This information will be revised for personalization of the Policy upon issue.
5.	Specifications	Header	This information will be revised for personalization of the Policy upon issue.
6.	Specifications	Replacement	This section may be omitted in its entirety.
7.	Specifications	Existing Effective Date	This section may be omitted in its entirety.
8.	Specifications	Existing Term Date	This section may be omitted in its entirety.
9.	Specifications	Products Replaced	This section may be omitted in its entirety.
10.	Specifications	Takeover Credit	This section may be omitted in its entirety.
11.	Specifications	Takeover Documentation	This section may be omitted in its entirety.
12.	Fraud Notice	Fraud Notice	The Fraud Notice may be revised for state statutory or regulatory changes or to include only the state applicable to state-specific forms.
13.	Agent's Report	Requested Initial Deposit	This section may be omitted in its entirety.